A variety of ambulatory procedures commonly performed on persons 15–44 years of age included endoscopy of small intestine (419,000), endoscopy of large intestine (380,000), laparoscopy (334,000), excision or destruction of lesion or tissue of skin and subcutaneous tissue (330,000), arthroscopy of knee (325,000), dilation and curettage of uterus (318,000), and bilateral destruction or occlusion of fallopian tubes (314,000).

For persons 45–64 years of age, endoscopy of large intestine (696,000) and endoscopy of small intestine (502,000) were frequent ambulatory procedures.

Common ambulatory procedures for persons 65 years of age and over were extraction of lens (1,977,000), insertion of prosthetic lens (1,501,000), endoscopy of large intestine (822,000), and endoscopy of small intestine (614,000).

Diagnoses for Ambulatory Surgery Visits

Diagnoses for 500,000 or more ambulatory surgery visits included cataract (2,328,000); benign neoplasms (993,000), especially benign neoplasm of colon (586,000); malignant neoplasms (785,000); rheumatism (616,000); and inguinal hernia (515,000) (table 7).

Rates of ambulatory surgery visits per 10,000 population were higher for males than for females for first-listed diagnoses of otitis media and Eustachian tube disorders (23.1 versus 14.9), heart disease (19.5 versus 11.4), deviated nasal septum (6.5 versus 4.8), inguinal hernia (35.9 versus 3.9), calculus of kidney and ureter (9.3 versus 5.1), fractures (13.8 versus 8.6), and current tear of medial cartilage or meniscus of knee (12.4 versus 7.0).

Introduction

This report presents data from the 1996 National Survey of Ambulatory Surgery (NSAS), which was initiated by the National Center for Health Statistics in 1994 to gather and disseminate data about ambulatory surgery. For NSAS, ambulatory surgery refers to surgical and nonsurgical procedures performed on an ambulatory (outpatient) basis in a hospital or freestanding center’s general operating rooms, dedicated ambulatory surgery rooms, and other specialized rooms such as endoscopy units and cardiac catheterization labs.

Ambulatory surgery has been increasing in the United States since the early 1980’s. Two major reasons for the increase are advances in medical technology and cost containment initiatives. The medical advances include improvements in anesthesia, which enable patients to regain consciousness more quickly with fewer after effects, and better analgesics for relief of pain. In addition, minimally invasive and noninvasive procedures are being developed and performed with increasing frequency. Examples include laser surgery, laparoscopy, and endoscopy. These medical advances have made surgery less complex and risky (1).

At the same time, concern about rising health care costs led to changes in the Medicare program that encouraged the development of ambulatory surgery. In the early 1980’s, the Medicare program was expanded to cover care in ambulatory surgery centers, and a prospective payment system based on diagnosis-related groups (DRG’s) was adopted for hospital inpatient care that