Table 3. Japanese classification, 12th edition; 1993 (1st English edition; 1995 [12])

		P0, H0, M0				P0, H1, N0-2
		N0	N1	N2	N3	
P0 H0 M0	T1	Ia	Ib	II	IIIa	IVa
	T2	Ib	II	IIIa	IIIb	
	T3	II	IIIa	IIIb	IVa	
	T4	IIIa	IIIb	IVa	IVb (N4, P2,3, H2,3, M1, etc)	
P1, H0, T1-3		IVa				

Table 4. Japanese classification, 13th edition; 1999 (2nd English edition; 1998 [3])

		M0				M1
		N0	N1	N2	N3	
M0	T1	IA	IB	II	IV	
	T2	IB	II	IIIA		
	T3	II	IIIA	IIIB		
	T4	IIIA	IIIB	IV		
H1, P1, CY1, M1						

(left paracardial) nodes in the case of antral tumors. Other node groups, such as 14v (nodes along the superior mesenteric vein) and 12a (along the proper hepatic artery) are common sites of nodal metastasis for lower gastric tumors, and their dissection, even when positive, is often associated with survival. These groups have thus been brought into the N2 tier from the previous N3 tier. As a consequence, the D2 dissection, including all N2 node stations, is more radical than was previously the case, and is better targeted to actual rather than theoretical patterns of spread. D2 dissection can now be applied as standard surgical treatment for advanced gastric cancer. D3 dissection should be regarded as investigational treatment and is not standard. Following the revision of the N staging, there is no longer a category of "D4" dissection. The effect of the changes on stage grouping is that all N3 disease is regarded as stage IV, which is now no longer substratified.

There was a striking resemblance in the staging tables between the second English edition of the JGCA classification (Table 4) and the fifth edition of the TNM classification (Table 2), with the only difference being for the assignment of T4N1 disease, although the definition of N is totally different, as mentioned.

Evaluation and comparison

Similarities and contrasts between staging systems

Unification of staging systems or the concepts of staging is desirable and dialogue between Japanese and Western groups has resulted in alterations in both staging systems to take account of their different approaches.

In 1978, the UICC refined the anatomical-based N grouping into two tiers to reflect radial nodal spread, in keeping with the Japanese principles. N1 involvement was confined to perigastric nodes close to the primary, and N2 nodes referred to those along the hepatic, left gastric, splenic, or celiac arteries, as well as more distant perigastric nodes. This allowed some comparison between Japanese and UICC classifications, as N1 and N2 nodes corresponded to some extent across the two systems, although the anatomical details differed considerably.

The recent change of TNM staging to a number-based node status was a major turnaround that might separate irreversibly the two classifications, which had been converging. However, as far as prognosis is concerned, it has made direct comparison between Western and Japanese patients much easier, as the same data are available for both sets of patients. Now the clinical data recorded by the JGCA system can be exactly translated to the TNM system. The opposite is totally impossible, because the number-based system is a post-hoc pathological staging and bears no relationship to patterns of lymph node spread.

By contrast with the JGCA classification, which provides comprehensive and meticulous guidance to clinicians, the TNM classification is a simple staging system. There is little guidance on management, except that a minimum of 15 lymph nodes is recommended for accurate staging. The stage stratification from the TNM system is simple to apply and gives good prognostic information, but the use of lymph node number alone means that, without supplementary information, stage-dependent management cannot be practiced before final histology is available, as it is impossible to assess the exact number of positive lymph nodes radiologically or even surgically.

Differences in surgical philosophy between Japan and the West

It was Moynihan [15] who said that "Surgery of malignant disease is not the surgery of organs; it is the

anatomy of the lymphatic system". This is undoubtedly a basic principle of Japanese surgical practice. The commonest site of metastasis for gastric cancer is to lymph nodes. Japanese surgeons believe lymph node metastasis is orderly and progresses through the tiers of nodes in a stepwise manner. By defining the lymph node groups in each tier, the surgeon can remove all nodes to the level above that in which positive nodes are apparent or likely, on the basis of preoperative and intraoperative staging.

The JGCA classification is much more than a simple staging system, as it outlines a whole approach to gastric cancer. Rules are defined for diagnosis, surgical procedures, histology, and staging, as well as details of how to prepare the surgical specimen and lymph nodes. The JGCA classification details which node groups to remove depending on the site of the tumor and the level of dissection required. Stage grouping for prognosis naturally uses the same nodal tier basis for N-stage stratification, as it reflects both the spread of the disease and its treatment strategy.

On the other hand, the focus in Western surgical philosophy has been that prognosis is determined to a great extent by the biology of the primary tumor, and that lymph node metastasis is a marker of tumor dissemination [16]. Extended clearance of lymph nodes, unless obviously involved, is perceived to incur excessive morbidity with doubtful survival advantage. Thus, the TNM system places emphasis on prognostic staging and provides little treatment guidance.

Nevertheless, some European surgical groups consider the extended lymphadenectomy as an effective local tumor control and continue to employ D2 dissection and Japanese style N-staging [17].

Prognostic value

Japanese versus TNM classification. Since the introduction of number-based nodal staging in the UICC/TNM system, several Japanese authors have been able to compare prognosis by Japanese and TNM staging in the same patients.

In a study by Fujii et al. [18], 1489 patients were classified retrospectively according to the two classifications. They found that the survival curves in relation to the nodal staging of the two classifications were more or less similar, in that a decrease in survival was associated with an increase in the nodal classification. However, there was more homogeneity in the TNM stage groups than with the JGCA: when the patients with "n1" metastasis by the JGCA system were subdivided according to the TNM number-based system, there were significant differences in survival between "n1/pN1" and "n1/pN2". The same was true for JGCA "n2" patients classified as pN1 or pN2 by TNM stage. However, there was no difference in survival when each of TNM pN1 and pN2 groupings was subdivided into JGCA "n1" and "n2", i.e., patients with "pN1/n1" or "pN1/n2" shared similar survival curves, as did those with "pN2/n1" and "pN2/n2". This suggests that the prognostic impact of TNM pN stage is superior to that of JGCA "n" staging.

Ichikura et al. [19], Hayashi et al. [20] and Ichikawa et al. [21] also published their results from patients who underwent clinically curative gastric resection, using the JGCA and the fifth TNM classifications. All three groups of authors concluded that the TNM classification for lymph node involvement was superior to the JGCA classification in terms of homogeneity and prognostic value.

Similar conclusions were drawn by Kodera et al. [22], and they found that, even when lymphadenectomy was limited to perigastric lymph nodes, as in a standard Western style D1 resection, there was a difference in survival between pN1 and pN2, which supports the use of the new TNM classification.

In summary, therefore, the number-based N staging has greater prognostic power than the anatomical-based system.

Old TNM (1987) versus new TNM (1997) classification. Direct comparisons of the old and new TNM systems have been published by a variety of authors. Katai et al. [23] analyzed the results of 4362 patients who underwent resection for gastric cancer and found that the new system provided better prognostic stratification than the old system. However, patients classified as "pT4N1" in the new system fared better than other patients in stage IV and would have been better classified as stage IIIB.

Karpeh et al. [24] looked at the old and new AJCC/TNM classifications in 1038 patients, the majority of whom had undergone extended lymph node dissection; they also concluded that node numbers provided more homogeneous survival curves and better prediction of outcome than sites of metastases as defined by the 1987 AJCC/TNM criteria. These authors also strongly countenanced the minimum requirement of 15 nodes to limit stage migration.

Kranenbarg et al. [25] evaluated the old and new TNM classifications for their practicality and prognostic value, using the data of 1078 patients from the Dutch Gastric Cancer Trial. They found that the new (1997) TNM classification gave better prognostic stratification than the old (1987) classification.

The above studies differed from the conclusion reached by Mendes-de-Almeida et al. [26], who found the new TNM classification not very effective in improving the prognostic stratification of lymph node involvement when compared with the old TNM classification. A similar conclusion was drawn by de Manzoni et al.

[27], who concluded that both the site and the number of positive lymph nodes were independent prognostic factors in gastric cancer. Lee et al. [28] did not find superiority of the new classification, and questioned the validity of the current cutoff point for N-staging.

Practicalities of the classifications

Pre- and intraoperative staging. The TNM staging system was originally designed to help plan management before any treatment, and it is often applied in a preintervention setting, but offers little descriptive information on gastric cancer. Treatment planning often relies on supplementary information, in addition to the TNM or stage descriptor.

The recent change in TNM nodal staging further limits the ability to accurately stage patients before treatment. It is true that, in any case, the preoperative assessment of regional lymph nodes in gastric cancer using radiological imaging methods has a low accuracy rate, but counting involved lymph nodes radiologically is impossible, whereas identification of the sites of abnormal nodes is included within standard radiological reporting. Because neoadjuvant chemotherapy is attracting increasing interest today, the importance of pretreatment staging inevitably increases. The N-staging of the current TNM system does not function in this regard, and some modification might be required in the future.

The intraoperative findings during surgery may include macroscopic laparotomy findings, frozen section examination, cytology results, and the macroscopic findings of the resected specimen. Within the JGCA classification, there is clear guidance on the relevance of metastatic disease in the peritoneal cavity or any of the relevant lymph node groups, enabling surgical strategy to be decided on the basis of knowledge of the likely oncological outcome of the patient. While all the same information is available to the Western surgeon, TNM staging has little to offer in regard to strategy, unless frank, previously unrecognized metastases are found.

One example is positive peritoneal cytology, which represents stage IV disease by the current JGCA classification and is equivalent to distant metastasis in terms of prognosis. A positive finding will render a procedure palliative [29,30], and should restrict the need to pursue a radical resection.

Peritoneal cytology is not represented in the current TNM classification, and requires additional annotation if it is to be included in trials or treatment protocols.

Lymph node retrieval. The processing of lymph nodes is detailed and time-consuming with the Japanese system [31], and has been criticized for being complicated and unnecessarily labor-intensive, as it is performed by the surgical team. By contrast, in the West, the pathologist is in charge of the resected specimen, is often unaware of the precise location of the relevant lymph nodes, and is unlikely to be able to allocate each lymph node to its corresponding site and tier following an en-bloc resection. Now the number-based system can be easily applied in the West.

The TNM classification stated, in the fifth edition that, for pN0, "histological examination of a regional lymphadenectomy specimen will ordinarily include 15 or more lymph nodes". While many authors have supported the validity of the minimal number of 15 for staging [32,33], some surgeons have suggested that it could be reduced without influencing the prognostic analysis, thereby considerably reducing "unclassified (pNX)" cases. Kranenbarg et al. [25] suggested that a minimum of 5 consecutive negative nodes would suffice to stage gastric cancer as pN0, based on the data from the Dutch D1/D2 trial. Ichikura et al. [34] found that the survival rate for patients with 10 to 14 negative nodes was as good as the rate for those with 15 or more negative nodes, and suggested that the minimum number to be examined for pN0 could be reduced to 10.

In the latest edition of the TNM classification, the following sentence has been added to the pN0 definition: "If the lymph nodes are negative, but the number ordinarily examined is not met, classify as pN0". This appears to mean that the figure of 15 is a recommendation, but no longer a requirement, for pN0 staging.

In node-positive patients, the current TNM classification may cause serious problems of underestimation. For example, if 6 lymph nodes only were retrieved, and all were positive for cancer cells, the staging would be assigned as pN1 in this system. It is highly likely that such a patient would have had further positive nodes that had been dissected, but not retrieved, and thus could have been staged as pN2 or pN3 if 16 or more nodes had been retrieved. This is not an unlikely situation in Western general hospitals; Mullaney et al. [35] assessed the number of lymph nodes documented for surgically managed patient in the West Midlands, United Kingdom, and found that only 31% of surgically resected patients could be staged with at least 15 nodes.

Furthermore, some authors have even suggested that 15 nodes may not be sufficient for accurate staging of metastatic nodes. Lee et al. [36] reported a retrospective analysis of 4789 patients with gastric cancer and suggested that, for advanced disease and in particular for stage IIIB, more than 15 nodes may be required for optimal staging. They indicated that, with a smaller number of nodes examined, there is a high possibility of underestimation and stage migration.

Ichikura et al. [34] emphasized that, though the mini-

mum number for pN0 could be reduced from 15 to 10, accurate staging of pN1 and pN2 requires the examination of 20 or more nodes, because the number of metastatic nodes was significantly correlated with the number of examined nodes.

Stage migration. The issue of stage migration, or the "Will Rogers phenomenon" [37], is frequently cited as a potential cause of differences in outcome between Japanese and Western patients [1]. Japanese patients undergo D2 dissection as the standard treatment, and, because more nodes are harvested, they are more likely to have positive nodes picked up compared to D0/D1 gastrectomy. The same patients in an extended lymphadenectomy series will thus be allocated a worse prognostic stage than their counterparts who had a D0/D1 gastrectomy. This will improve the survival data for all stages, purely by reallocation of patients with lymph node metastases into higher stages [38].

The introduction of the number-based N-staging may reduce stage migration among the groups with different extents of lymphadenectomy [39], if the resected nodes are fully retrieved. However, enthusiasm for nodal retrieval rather than extent of lymphadenectomy may directly influence the N-staging in this system.

Japanese surgeons usually retrieve as many lymph nodes as possible, because the nodes are literally their "harvest" of cancer surgery, while Western pathologists would be reluctant to retrieve more than the minimum requisite. The only means to prevent or minimize stage migration in the number-based system is to keep nodal retrieval at a high level (e.g., at least 15). Now that the minimum requisite of 15 is practically abolished in the sixth TNM edition, underestimation and consequent stage migration may further enlarge the apparent differences in treatment results between Japan and the West.

Other Classifications

Numerous classifications have been proposed by individual groups after sub-analysis of their own data. Most are adaptations of either anatomical or numerical systems of N-staging, as in the two major classifications.

Adachi et al. [40] and Whiting et al. [41] both employ anatomical nodal staging, with junctional nodes between conventional N1 and N2 tiers. Whiting et al. [41] suggested that junctional nodes could be assessed during surgery to decide whether or not to proceed to D2 dissection, if these nodes were involved. The rationale is based on the apparently high morbidity of D2 dissection in Western series, and they suggested that D2 dissection should be avoided if possible.

Kato et al. [42] address the issue of limited nodal dissection and describe the predictive value of the number of metastatic nodes in the Japanese (old and new classifications) "n1" perigastric stations. They found their system to have higher sensitivity, specificity, and accuracy than the TNM system or the Japanese system.

Finally, Yu et al. [43] have proposed a frequency system, based on the ratio of metastatic to dissected regional lymph nodes (more or less than 25% involved). Such a system weights against limited nodal dissection, and is a relevant approach, assuming extended lymphadenectomy has an independent survival impact.

Conclusion

Despite repeated comparisons between Japanese and Western staging systems, the systems do not, and were not designed to, fulfill the same role. The JGCA classification is a comprehensive guide to the anatomical-based treatment of gastric cancer and its regional metastases. The staging system within the JGCA classification is highly detailed and anatomically based, and it is inseparable from the guidance on surgical treatment, which is its primary focus.

The TNM system is primarily used as a guide to prognosis. It contains no treatment guidance and has recently changed to a number-based N stage, which most accurately reflects metastatic burden and, hence, prognosis. It provides a simple and reliable means of comparison of outcome between series. In Western practice, importance is placed on both surgeon and pathologist to ensure a nodal yield of at least 15 nodes. The value of the number-based nodal system for comparison will be lost if node yields are low, as a consequence of stage migration, and comparison between patients classified by the TNM and Japanese systems will remain inadequate, as the Japanese approach of D2 dissection and specimen preparation invariably results in greater node yields.

As the two systems are different in principle, it is important that clinicians involved in the treatment of gastric cancer understand the roles of each system. Surgeons using the Japanese system are able to report results by both the Japanese and the TNM staging, which will help comparisons of outcome. However, the two systems are not interchangeable, and the systems and their terminology should not be mixed if clarity is to be maintained.

Alternative staging systems continue to be proposed. Most adapt either anatomical or number-based systems, confirming the independent value of each approach.

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資料

がん診療の経済的な負担に関するアンケート調査
仮集計結果

調査方法

1) 各施設の倫理委員会の承認のもとで実施する。

2) 調査対象

外来等を受診したがん患者で、下記をすべて満たす者。

① 初診を除く(紹介の場合は初診も可)。

② 15才以上。

③ がんの診断が確定し、治療を開始または終了している。

④ がんの告知を受け、病態を理解している。

⑤ 調査の趣旨を理解し、調査に協力してくれる。

3) 研究組織

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がん診療の経済的な負担に関するアンケート調査

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第 3 次対がん総合戦略研究事業

「がん医療経済と患者負担最小化に関する研究」
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＜調査の趣旨＞

このアンケートは、がん診療を受けておられる患者さんの経済的な負担を把握するためのものです。

質が高く安全で、患者さんの経済的な負担ができるだけ少ない、優れたがん医療の実践に向けた基礎資料を得ることを目的としています。

＜お願い＞

このアンケートは、がん診療で外来を受診している全国の患者さんを対象にしております。

日数や金額などをおたずねする項目では、過去の領収書などを参考にしながらお答え下さい。正確にわからない場合は、おおよそで結構です。

お名前を書いていただく必要はありません。ご回答は統計的に処理されますので、個人が特定されることはありません。

まことに恐れ入りますが、ご回答いただいた調査票は1週間程度で、ご返送下さい。返信用の封筒に切手はいりません。何とぞ、よろしくお願い申し上げます。

＜お問い合わせ先＞

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東北大学大学院　医学系研究科　医療管理学分野

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記入日	月	日

1 通院・入院について

1-1 自宅から病院までの交通手段、あてはまるものを○で囲んで下さい。

徒歩	電車	自家用車	飛行機
バス	新幹線	タクシー	その他(　　)

1-2 通院時間は片道どのくらいですか。

時間	分くらい

1-3 通院にかかる交通費(宿泊費を含む)は、往復でいくらですか。

ご自身	円くらい	つきそいの方	円くらい

1-4 通院回数はどのくらいですか。

1ヶ月間に	回くらい	1年間に	回くらい

1-5 いまの病気(がん)で、これまで何ヶ所の病院・診療所(現在受診中も含む)を受診しましたか。

ヶ所

1-6 いまの病気(がん)で、これまで何回入院しましたか。

回

1-7 昨年1年間(1月1日～12月31日)の入院期間は、合計しておよそ何日でしたか。

日

2 いまの病気(がん)によって、ご自身の仕事にどのような影響がありましたか。あてはまるものに○をつけて下さい。

1 お勤めの方
2 自営業の方
3 お勤め・自営業以外の方

1 専業主婦
2 学生
3 無職
4 その他(　　)

1 特に影響はない
2 これまでのように仕事をこなすことができない
3 仕事を休むことが多くなった
4 仕事をやめた・解雇された
5 勤務時間が減った
6 給料が減った
7 異動・配置換えとなった
8 その他(　　)

1 特に影響はない
2 これまでのように仕事をこなすことができない
3 仕事を休むことが多くなった
4 休業・廃業した
5 営業時間が短くなった
6 収入が減った
7 転業した
8 その他(　　)

3 いまの病気(がん)によって、経済的にどのような影響を受けましたか。

1 変らない
2 ご自身の支出が増えた → 約(　　)割の増加
3 ご家族の支出が増えた → 約(　　)割の増加
4 ご自身の収入が減った → 約(　　)割の減少
5 ご家族の収入が減った → 約(　　)割の減少
6 その他 (　　)

4 いまの病気(がん)に関する支出について

4-1 病院や薬局の窓口で支払った金額はいくらですか。

	入院分	外来分
先月1ヶ月間	円	円
昨年1年間	円	円

4-2 健康食品や民間療法などの支出額はいくらですか。

先月1ヶ月間	円	昨年1年間	円

4-3 その他の支出額(贈答費・かつら代など)はいくらですか。

先月1ヶ月間	円	昨年1年間	円

4-4 民間保険・簡易保険・県民共済などの保険料はいくらですか。

先月1ヶ月間	円	昨年1年間	円

5 いまの病気(がん)の給付について

5-1 高額療養費として、戻ってきた金額はいくらですか。

昨年1年間	円

5-2 医療費還付として、戻ってきた税金はいくらですか。

昨年1年間	円

5-3 民間保険・簡易保険・県民共済などから受け取った金額(入院給付金など)はいくらですか。

先月1ヶ月間	円	昨年1年間	円

6 いまの病気(がん)の経済的負担について、病院から説明がありましたか。○をつけて下さい。

1 十分な説明を受けた
2 説明を受けたがわからなかった
3 説明はなかった
4 覚えていない

→ 説明した人を○で囲んで下さい。

医師　看護師　その他の職員(　　)

7 いまの病気(がん)の経済的負担について、病院以外の情報源は何ですか。

1 雑誌・本
2 新聞
3 テレビ・ラジオ
4 インターネット
5 講演会
6 相談窓口
7 患者団体
8 保険外交員
9 家族・親戚
10 友人・知人
11 その他
(　　)

8 いまの病気(がん)の経済的負担について、外部の人に相談しましたか。

1 相談した → 相談先
2 相談していない → その理由

相談先
1 病院の相談窓口
2 役所の相談窓口
3 地域の世話人(民生委員など)
4 民間団体(NPOなど)
5 同じ病気の人
6 その他(　　)

その理由
1 相談しなくてもよい
2 相談したくない
3 相談したいができなかった

続く

9 いまの病気(がん)の経済的負担について、特に希望するものを3つまで(その他を含む)選び○をつけて下さい。

1 もっと情報がほしい
2 気軽に相談できるところがほしい
3 自宅の近くに、がん専門病院があってほしい
4 自己負担が多くなっても(保険適用外でも)、がん診療を続けたい
5 もし選べるなら、経済的負担の少ない治療(お薬)にしてもらいたい
6 がん診療の自己負担は、他の病気より軽くしてほしい
7 がん診療での特定療養費制度(室料差額など)の対象をひろげてもらいたい。
8 高額療養費の限度額を引き下げてもらいたい
9 がん診療は全額公費負担にしてもらいたい
10 外国でがん診療を受けた場合も、公的保険を適用してもらいたい
11 民間保険の内容・給付額を充実してもらいたい
12 その他

(　　)

10 ご自身について

10-1

年齢	歳	性別	男　女	居住地	都道府県

10-2 いまの病気(がん)と診断されたのは　平成　　年　　月頃　あるいは　　年前

10-3 がんと診断されたとき、それはどの部位でしたか(複数の場合は主たる部位)。○で囲んで下さい。

食道	胃	結腸	直腸	肝臓	胆管	すい臓		
肺	胸膜	乳房	子宮	卵巣	膀胱	腎臓	前立腺	精巣
血液	脳	いん頭	こう頭	舌	口腔	甲状腺		
骨	筋肉	リンパ腫	皮膚	その他 (　　)				

10-4 いまの病気(がん)の治療状況について、1つに○をつけて下さい。
1 がんに対する治療を継続中
2 がんに対する治療は終了し、検査などで通院中
3 その他(　　)

10-5 いままで受けた治療、すべてに○をつけて下さい。

1 外科手術(内視鏡手術を含む)	4 放射線療法	7 リハビリテーション
2 薬物療法(抗がん剤など)	5 緩和ケア	8 ストーマケア(人工肛門など)
3 内分泌療法(ホルモン剤など)	6 在宅ケア	9 その他(　　)

ご協力、どうもありがとうございました。

全体 (3,299件中)

問番号	内容	すべての回答						"0"		"0" 以外				
		件数	平均	中央値	標準偏差	最大値	最小値			回答件数		平均	中央値	標準偏差
Q1-2	片道の通院時間	3,219	58.15	50.	77.85	3,000	2							
Q1-3	往復交通費 - 本人	2,456	2,230.59	1,000.	4,876.42	75,000	0	137	(5.6%)	2,319	(94.4%)	2,362.37	1,060.	4,987.29
	往復交通費 - つきそい	827	2,463.62	1,000.	6,305.71	80,000	0	144	(17.4%)	683	(82.6%)	2,983.04	1,200.	6,826.11
Q1-4	1ヶ月の通院回数	1,792	2.49	1.	3.55	30	0	4	(0.2%)	1,788	(99.8%)	2.50	1.	3.55
	1年間の通院回数	2,278	11.97	6.	15.12	200	0	1	(0.0%)	2,277	(100.0%)	11.98	6.	15.13
Q1-5	(現在も含め)これまで受診した病院・診療所の数	3,173	1.87	2.	1.03	24	0	68	(2.1%)	3,105	(97.9%)	1.91	2.	1.00
Q1-6	これまで入院した回数	3,153	1.96	1.	2.50	60	0	189	(6.0%)	2,964	(94.0%)	2.08	1.	2.53
Q1-7	昨年1年間の合計入院期間	2,684	21.94	5.	38.13	400	0	1,202	(44.8%)	1,482	(55.2%)	39.74	23.	43.89
Q4-1	入院分(月)	1,070	98,609.76	0.	234,688.34	5,000,000	0	613	(57.3%)	457	(42.7%)	230,880.62	150,000.	313,719.47
	外来分(月)	2,219	22,563.79	8,000.	103,524.08	4,500,000	0	324	(14.6%)	1,895	(85.4%)	26,421.66	10,550.	111,569.24
	入院分(年)	1,434	349,818.11	150,000.	581,358.90	6,500,000	0	443	(30.9%)	991	(69.1%)	506,194.92	300,000.	640,238.33
	外来分(年)	2,241	124,767.63	50,000.	236,648.91	4,200,000	0	167	(7.5%)	2,074	(92.5%)	134,814.02	60,000.	243,223.55
Q4-2	健康食品・民間療法(月)	1,925	17,211.85	5,000.	46,566.45	1,000,000	0	761	(39.5%)	1,164	(60.5%)	28,464.61	11,000.	57,147.24
	健康食品・民間療法(年)	2,050	126,924.04	25,000.	328,384.10	6,000,000	0	795	(38.8%)	1,255	(61.2%)	207,326.12	100,000.	399,345.95
Q4-3	その他の支出額(月)	1,405	17,396.26	0.	69,278.98	1,500,000	0	1,059	(75.4%)	346	(24.6%)	70,640.88	30,000.	125,412.78
	その他の支出額(年)	1,659	49,886.00	0.	119,037.45	1,300,000	0	1,004	(60.5%)	655	(39.5%)	126,352.49	70,000.	161,951.16
Q4-4	保険料(月)	1,740	20,812.58	12,792.5	43,837.60	1,000,000	0	356	(20.5%)	1,384	(79.5%)	26,166.11	17,000.	47,707.16
	保険料(年)	2,077	213,050.56	150,000.	272,490.16	5,000,000	0	318	(15.3%)	1,759	(84.7%)	251,566.80	180,000.	279,257.75
Q5-1	高額医療費として、戻ってきた金額は	1,968	126,649.63	0.	302,802.50	5,000,000	0	1,010	(51.3%)	958	(48.7%)	260,173.77	142,413.5	391,938.91
Q5-2	医療費還付として、戻ってきた税金は	1,552	18,539.94	0.	99,723.82	2,970,000	0	1,190	(76.7%)	362	(23.3%)	79,486.14	30,000.	194,401.82
Q5-3	保険給付金(月)	1,392	102,188.85	0.	434,321.82	6,000,000	0	1,156	(83.0%)	236	(17.0%)	602,741.01	270,000.	900,514.35
	保険給付金(年)	1,882	401,880.72	0.	929,979.65	8,200,000	0	1,077	(57.2%)	805	(42.8%)	939,552.19	465,000.	1,231,576.47
Q10-1	年代	3,241	63.10	65.	12.54	94	3							
Q10-2	がんと診断された時期 - "x年y月"の回答	3,004	3.67	2.	3.25	25	0							

治療継続中 (1,325件中)

問番号	内容	すべての回答						"0"		"0" 以外			
		件数	平均	中央値	標準偏差	最大値	最小値			回答件数		平均	中央値	標準偏差
Q1-2	片道の通院時間	1,301	58.55	45.	111.76	3,000	2							
Q1-3	往復交通費 - 本人	998	2,390.05	1,035.	5,473.96	75,000	0	60	(6.0%)	938	(94.0%)	2,542.93	1,100.	5,611.79
	往復交通費 - つきそい	379	2,692.72	1,000.	7,621.04	80,000	0	64	(16.9%)	315	(83.1%)	3,239.82	1,200.	8,252.77
Q1-4	1ヶ月の通院回数	1,029	2.94	2.	3.94	30	0	1	(0.1%)	1,028	(99.9%)	2.94	2.	3.94
	1年間の通院回数	786	18.72	12.	18.67	182	2							
Q1-5	(現在も含め)これまで受診した病院・診療所の数	1,282	1.88	2.	0.90	7	0	23	(1.8%)	1,259	(98.2%)	1.91	2.	0.87
Q1-6	これまで入院した回数	1,252	2.16	1.	2.64	35	0	113	(9.0%)	1,139	(91.0%)	2.38	1.	2.67
Q1-7	昨年1年間の合計入院期間	1,095	21.31	6.	34.93	270	0	445	(40.6%)	650	(59.4%)	35.90	21.	39.14
Q4-1	入院分(月)	471	106,402.48	30,000.	179,494.84	1,700,000	0	216	(45.9%)	255	(54.1%)	196,531.64	125,620.	204,440.81
	外来分(月)	1,025	35,765.10	20,000.	147,479.71	4,500,000	0	50	(4.9%)	975	(95.1%)	37,599.20	20,000.	150,985.77
	入院分(年)	595	344,868.82	123,430.	619,208.20	6,500,000	0	174	(29.2%)	421	(70.8%)	487,403.68	250,000.	687,324.09
	外来分(年)	875	191,773.83	102,490.	305,067.05	4,200,000	0	92	(10.5%)	783	(89.5%)	214,306.64	125,600.	314,915.74
Q4-2	健康食品・民間療法(月)	827	24,337.02	6,910.	62,838.09	1,000,000	0	280	(33.9%)	547	(66.1%)	36,794.73	16,000.	74,239.36
	健康食品・民間療法(年)	799	155,475.49	36,000.	389,649.48	6,000,000	0	298	(37.3%)	501	(62.7%)	247,953.93	100,000.	468,192.73
Q4-3	その他の支出額(月)	599	24,198.07	0.	62,618.35	500,000	0	397	(66.3%)	202	(33.7%)	71,755.65	34,500.	90,635.36
	その他の支出額(年)	638	58,367.45	0.	129,474.25	1,200,000	0	372	(58.3%)	266	(41.7%)	139,994.12	80,000.	169,647.09
Q4-4	保険料(月)	743	21,110.21	12,000.	44,966.52	787,000	0	151	(20.3%)	592	(79.7%)	26,494.74	16,000.	48,939.46
	保険料(年)	810	218,427.21	150,000.	302,114.66	5,000,000	0	135	(16.7%)	675	(83.3%)	262,112.65	180,000.	313,173.14
Q5-1	高額医療費として、戻ってきた金額	813	124,293.44	6,500.	296,556.76	2,806,430	0	360	(44.3%)	453	(55.7%)	223,069.68	79,950.	368,514.20
Q5-2	医療費還付として、戻ってきた税金	617	18,333.51	0.	63,869.55	1,000,000	0	440	(71.3%)	177	(28.7%)	63,908.32	30,000.	106,336.21
Q5-3	保険給付金(月)	607	135,961.93	0.	505,202.44	6,000,000	0	466	(76.8%)	141	(23.2%)	585,311.30	250,000.	914,190.74
	保険給付金(年)	747	352,701.62	0.	801,650.44	6,200,000	0	430	(57.6%)	317	(42.4%)	831,129.69	420,000.	1,056,755.50
Q10-1	年齢	1,317	64.57	67.	12.45	94	3							
Q10-2	がんと診断された時期 - "x年前"の回答	1,251	3.21	2.	3.15	25	0							

胃 - 全例 (399件中)

問番号	内容	すべての回答						"0"		"0" 以外			
		件数	平均	中央値	標準偏差	最大値	最小値			回答件数		平均	中央値	標準偏差
Q1-2	片道の通院時間	390	53.57	50.	35.74	240	5	0	(0.0%)	390	(100.0%)	53.57	50.	35.74
Q1-3	往復交通費 - 本人	301	1,659.80	1,000.	2,306.98	15,000	0	15	(5.0%)	286	(95.0%)	1,746.85	1,000.	2,334.36
	往復交通費 - つきそい	111	1,633.96	1,000.	2,436.72	14,000	0	14	(12.6%)	97	(87.4%)	1,869.79	1,100.	2,520.63
Q1-4	1ヶ月の通院回数	174	1.99	2.	1.36	8	1	0	(0.0%)	174	(100.0%)	1.99	2.	1.36
	1年間の通院回数	280	8.10	4.	9.49	60	0	1	(0.4%)	279	(99.6%)	8.13	4.	9.50
Q1-5	(現在も含め)これまで受診した病院・診療所の数	387	1.83	2.	1.41	24	0	7	(1.8%)	380	(98.2%)	1.87	2.	1.40
Q1-6	これまで入院した回数	393	1.41	1.	1.07	9	0	12	(3.1%)	381	(96.9%)	1.45	1.	1.06
Q1-7	昨年1年間の合計入院期間	320	15.40	0.	23.37	120	0	161	(50.3%)	159	(49.7%)	30.99	21.	24.83
Q4-1	入院分(月)	128	111,792.86	0.	219,633.93	1,700,000	0	67	(52.3%)	61	(47.7%)	234,581.74	120,000.	269,107.64
	外来分(月)	263	14,013.39	5,000.	22,842.23	226,000	0	41	(15.6%)	222	(84.4%)	16,601.45	6,260.	23,982.58
	入院分(年)	149	242,502.84	120,000.	331,092.02	2,500,000	0	56	(37.6%)	93	(62.4%)	388,526.05	303,440.	344,814.45
	外来分(年)	265	60,906.61	26,160.	100,470.26	680,000	0	22	(8.3%)	243	(91.7%)	66,420.79	30,000.	103,159.59
Q4-2	健康食品・民間療法(月)	240	15,694.35	5,000.	44,841.54	600,000	0	88	(36.7%)	152	(63.3%)	24,780.56	10,000.	54,311.41
	健康食品・民間療法(年)	252	97,388.41	16,500.	296,880.24	3,336,000	0	101	(40.1%)	151	(59.9%)	162,529.01	50,000.	369,464.19
Q4-3	その他の支出額(月)	182	23,805.57	0.	126,171.60	1,500,000	0	139	(76.4%)	43	(23.6%)	100,758.47	30,000.	244,183.51
	その他の支出額(年)	202	38,193.64	0.	94,156.25	600,000	0	137	(67.8%)	65	(32.2%)	118,694.09	50,000.	134,149.20
Q4-4	保険料(月)	228	24,290.17	13,000.	70,117.32	1,000,000	0	47	(20.6%)	181	(79.4%)	30,597.56	20,000.	77,460.26
	保険料(年)	266	223,405.76	150,650.	311,613.24	3,099,588	0	41	(15.4%)	225	(84.6%)	264,115.25	200,000.	322,560.23
Q5-1	高額医療費として、戻ってきた金額	230	66,666.68	0.	141,339.81	690,000	0	150	(65.2%)	80	(34.8%)	191,666.71	150,000.	182,962.75
Q5-2	医療費還付として、戻ってきた税金	200	11,601.49	0.	44,370.09	338,914	0	168	(84.0%)	32	(16.0%)	72,509.31	27,308.	88,814.54
Q5-3	保険給付金(月)	185	118,625.06	0.	387,646.71	3,300,000	0	151	(81.6%)	34	(18.4%)	645,459.91	385,000.	691,082.25
	保険給付金(年)	227	306,450.07	0.	700,505.60	4,500,000	0	149	(65.6%)	78	(34.4%)	891,848.28	600,000.	951,840.33
Q10-1	年齢	397	64.48	65.	10.48	89	27	0	(0.0%)	397	(100.0%)	64.48	65.	10.48
Q10-2	がんと診断された時期 - "x年前"の回答	379	3.67	3.	3.05	16	1	0	(0.0%)	379	(100.0%)	3.67	3.	3.05

大腸 - 全例 (150件中)

問番号	内容	すべての回答						"0"		"0" 以外			
		件数	平均	中央値	標準偏差	最大値	最小値			回答件数		平均	中央値	標準偏差
Q1-2	片道の通院時間	146	58.79	60.	33.36	200	5	0	(0.0%)	146	(100.0%)	58.79	60.	33.36
Q1-3	往復交通費 - 本人	114	1,840.09	920.	3,715.14	35,000	0	7	(6.1%)	107	(93.9%)	1,960.47	1,000.	3,803.85
	往復交通費 - つきそい	40	1,286.25	850.	2,027.96	13,000	0	3	(7.5%)	37	(92.5%)	1,390.54	980.	2,073.90
Q1-4	1ヶ月の通院回数	88	2.63	2.	2.82	25	1	0	(0.0%)	88	(100.0%)	2.63	2.	2.82
	1年間の通院回数	97	13.10	8.	12.09	50	1	0	(0.0%)	97	(100.0%)	13.10	8.	12.09
Q1-5	(現在も含め)これまで受診した病院・診療所の数	147	1.81	2.	0.80	5	0	2	(1.4%)	145	(98.6%)	1.83	2.	0.78
Q1-6	これまで入院した回数	143	1.93	1.	2.15	20	0	2	(1.4%)	141	(98.6%)	1.96	1.	2.15
Q1-7	昨年1年間の合計入院期間	118	23.40	14.5	34.01	180	0	45	(38.1%)	73	(61.9%)	37.82	25.	36.40
Q4-1	入院分(月)	57	128,687.54	0.	241,236.90	1,200,000	0	32	(56.1%)	25	(43.9%)	293,407.60	137,860.	290,439.38
	外来分(月)	104	32,259.71	13,905.	48,714.36	320,000	0	16	(15.4%)	88	(84.6%)	38,125.11	20,070.	50,802.96
	入院分(年)	66	351,092.11	150,000.	434,800.93	2,000,000	0	19	(28.8%)	47	(71.2%)	493,022.96	400,000.	442,155.97
	外来分(年)	91	150,833.09	60,000.	246,176.79	2,000,000	0	8	(8.8%)	83	(91.2%)	165,371.22	75,000.	253,061.41
Q4-2	健康食品・民間療法(月)	88	22,749.70	5,500.	43,083.99	250,000	0	33	(37.5%)	55	(62.5%)	36,399.53	20,000.	49,730.49
	健康食品・民間療法(年)	91	138,620.92	10,000.	255,724.94	1,500,000	0	42	(46.2%)	49	(53.8%)	257,438.86	120,000.	301,429.86
Q4-3	その他の支出額(月)	64	15,491.16	0.	37,465.25	200,000	0	44	(68.8%)	20	(31.3%)	49,571.70	35,000.	52,936.12
	その他の支出額(年)	70	54,377.14	0.	136,315.63	900,000	0	45	(64.3%)	25	(35.7%)	152,256.00	100,000.	192,683.21
Q4-4	保険料(月)	88	18,755.74	13,500.	17,959.57	80,000	0	14	(15.9%)	74	(84.1%)	22,304.12	18,000.	17,447.77
	保険料(年)	95	244,804.81	180,000.	232,763.39	960,000	0	9	(9.5%)	86	(90.5%)	270,423.92	200,000.	230,044.88
Q5-1	高額医療費として、戻ってきた金額	92	145,819.05	4,000.	224,515.43	1,018,832	0	45	(48.9%)	47	(51.1%)	285,433.04	256,000.	242,526.14
Q5-2	医療費還付として、戻ってきた税金	71	20,729.14	0.	50,403.93	270,000	0	49	(69.0%)	22	(31.0%)	66,898.59	40,000.	71,487.04
Q5-3	保険給付金(月)	67	119,574.63	0.	378,085.89	2,200,000	0	51	(76.1%)	16	(23.9%)	500,718.75	272,500.	638,555.16
	保険給付金(年)	89	702,741.78	7,000.	1,310,721.14	6,500,000	0	44	(49.4%)	45	(50.6%)	1,389,867.07	1,000,000.	1,562,942.56
Q10-1	年齢	150	63.89	65.	10.90	83	31	0	(0.0%)	150	(100.0%)	63.89	65.	10.90
Q10-2	がんと診断された時期 - "x年前"の回答	140	3.10	2.	2.74	15	1	0	(0.0%)	140	(100.0%)	3.10	2.	2.74

肺 - 全例 (215件中)

問番号	内容	すべての回答						"0"		"0" 以外			
		件数	平均	中央値	標準偏差	最大値	最小値			回答件数		平均	中央値	標準偏差
Q1-2	片道の通院時間	212	70.41	50.	205.04	3,000	5	0	(0.0%)	212	(100.0%)	70.41	50.	205.04
Q1-3	往復交通費 - 本人	161	2,444.84	1,080.	5,269.41	50,000	0	8	(5.0%)	153	(95.0%)	2,572.68	1,180.	5,374.91
	往復交通費 - つきそい	80	3,344.75	1,000.	9,578.31	61,000	0	6	(7.5%)	74	(92.5%)	3,615.95	1,080.	9,909.70
Q1-4	1ヶ月の通院回数	139	3.18	2.	4.33	30	1	0	(0.0%)	139	(100.0%)	3.18	2.	4.33
	1年間の通院回数	135	15.02	12.	16.56	144	1	0	(0.0%)	135	(100.0%)	15.02	12.	16.56
Q1-5	(現在も含め)これまで受診した病院・診療所の数	208	1.80	2.	0.89	5	0	6	(2.9%)	202	(97.1%)	1.86	2.	0.85
Q1-6	これまで入院した回数	206	2.22	1.	2.00	12	0	9	(4.4%)	197	(95.6%)	2.32	2.	1.99
Q1-7	昨年1年間の合計入院期間	170	33.13	20.5	43.15	194	0	67	(39.4%)	103	(60.6%)	54.68	40.	43.52
Q4-1	入院分(月)	87	119,463.53	60,000.	167,917.38	845,800	0	31	(35.6%)	56	(64.4%)	185,595.13	121,000.	177,570.21
	外来分(月)	148	26,528.46	10,000.	35,131.42	150,000	0	18	(12.2%)	130	(87.8%)	30,201.63	15,520.	35,974.61
	入院分(年)	98	444,395.98	203,000.	751,247.58	6,000,000	0	29	(29.6%)	69	(70.4%)	631,171.10	483,770.	826,853.13
	外来分(年)	128	128,341.25	39,340.	238,692.32	1,500,000	0	18	(14.1%)	110	(85.9%)	149,342.55	51,325.	251,317.85
Q4-2	健康食品・民間療法(月)	134	25,782.16	10,000.	50,143.88	400,000	0	47	(35.1%)	87	(64.9%)	39,710.46	20,000.	57,616.56
	健康食品・民間療法(年)	125	157,917.67	36,000.	267,730.18	1,320,000	0	51	(40.8%)	74	(59.2%)	266,752.82	134,500.	303,394.24
Q4-3	その他の支出額(月)	99	33,862.22	0.	80,676.10	500,000	0	59	(59.6%)	40	(40.4%)	83,809.00	36,750.	109,191.92
	その他の支出額(年)	96	44,509.03	0.	81,056.11	360,000	0	56	(58.3%)	40	(41.7%)	106,821.68	82,500.	95,456.19
Q4-4	保険料(月)	126	18,917.96	11,000.	25,524.96	200,000	0	24	(19.0%)	102	(81.0%)	23,369.25	18,000.	26,472.62
	保険料(年)	133	209,220.47	160,000.	262,406.27	2,400,000	0	19	(14.3%)	114	(85.7%)	244,090.54	192,444.	267,995.84
Q5-1	高額医療費として、戻ってきた金額	120	141,460.56	2,233.	228,453.58	1,360,326	0	56	(46.7%)	64	(53.3%)	265,238.55	225,866.	255,004.91
Q5-2	医療費還付として、戻ってきた税金	85	17,085.84	0.	66,312.47	473,578	0	69	(81.2%)	16	(18.8%)	90,768.50	23,127.	129,123.28
Q5-3	保険給付金(月)	100	223,288.64	0.	540,383.50	3,000,000	0	65	(65.0%)	35	(35.0%)	637,967.54	350,000.	754,834.40
	保険給付金(年)	115	523,346.05	34,995.	1,061,933.37	6,200,000	0	57	(49.6%)	58	(50.4%)	1,037,668.90	476,500.	1,304,708.78
Q10-1	年齢	214	66.43	67.	9.47	86	36	0	(0.0%)	214	(100.0%)	66.43	67.	9.47
Q10-2	がんと診断された時期 - "x年前"の回答	204	2.98	2.	2.70	18	1	0	(0.0%)	204	(100.0%)	2.98	2.	2.70

乳房 - 全例 (389件中)

問番号	内容	すべての回答						"0"		"0" 以外			
		件数	平均	中央値	標準偏差	最大値	最小値			回答件数		平均	中央値	標準偏差
Q1-2	片道の通院時間	382	54.27	50.	32.96	270	5	0	(0.0%)	382	(100.0%)	54.27	50.	32.96
Q1-3	往復交通費 - 本人	292	1,804.82	1,000.	4,172.35	50,000	0	7	(2.4%)	285	(97.6%)	1,849.15	1,000.	4,213.56
	往復交通費 - つきそい	61	1,772.95	1,000.	3,014.50	20,000	0	14	(23.0%)	47	(77.0%)	2,301.06	1,200.	3,252.51
Q1-4	1ヶ月の通院回数	173	3.64	2.	5.26	30	1	0	(0.0%)	173	(100.0%)	3.64	2.	5.26
	1年間の通院回数	274	12.99	5.	17.40	105	1	0	(0.0%)	274	(100.0%)	12.99	5.	17.40
Q1-5	(現在も含め)これまで受診した病院・診療所の数	371	1.80	2.	1.27	21	0	9	(2.4%)	362	(97.6%)	1.84	2.	1.26
Q1-6	これまで入院した回数	380	1.82	1.	3.22	35	0	15	(3.9%)	365	(96.1%)	1.89	1.	3.26
Q1-7	昨年1年間の合計入院期間	327	7.78	0.	14.06	105	0	164	(50.2%)	163	(49.8%)	15.61	11.	16.56
Q4-1	入院分(月)	134	54,670.70	0.	118,370.89	733,050	0	97	(72.4%)	37	(27.6%)	197,996.59	171,270.	149,555.74
	外来分(月)	258	29,514.44	17,995.	38,679.07	200,000	0	37	(14.3%)	221	(85.7%)	34,455.77	21,000.	39,702.48
	入院分(年)	194	192,765.55	135,000.	373,056.82	4,500,000	0	66	(34.0%)	128	(66.0%)	292,160.28	210,235.	426,488.50
	外来分(年)	284	168,680.32	88,100.	243,552.32	1,370,225	0	21	(7.4%)	263	(92.6%)	182,149.09	100,000.	248,195.09
Q4-2	健康食品・民間療法(月)	237	18,810.85	3,500.	75,099.53	1,000,000	0	102	(43.0%)	135	(57.0%)	33,023.50	11,000.	97,117.84
	健康食品・民間療法(年)	252	103,180.21	30,000.	190,045.69	1,400,000	0	95	(37.7%)	157	(62.3%)	165,614.09	100,000.	218,247.31
Q4-3	その他の支出額(月)	187	20,153.74	0.	49,466.05	250,000	0	137	(73.3%)	50	(26.7%)	75,375.00	50,000.	70,633.32
	その他の支出額(年)	226	66,457.34	12,500.	112,994.94	700,000	0	107	(47.3%)	119	(52.7%)	126,213.09	72,000.	129,252.62
Q4-4	保険料(月)	214	20,088.77	13,010.5	56,996.97	787,000	0	42	(19.6%)	172	(80.4%)	24,994.16	15,143.5	62,604.51
	保険料(年)	251	192,283.96	150,000.	177,034.41	1,129,995	0	27	(10.8%)	224	(89.2%)	215,461.04	164,184.	173,565.99
Q5-1	高額医療費として、戻ってきた金額	225	95,852.80	2,479.	175,059.91	1,102,455	0	112	(49.8%)	113	(50.2%)	190,857.34	130,839.	207,095.21
Q5-2	医療費還付として、戻ってきた税金	200	11,128.69	0.	27,762.97	200,000	0	141	(70.5%)	59	(29.5%)	37,724.37	23,000.	40,118.78
Q5-3	保険給付金(月)	162	112,092.59	0.	423,326.26	3,654,000	0	141	(87.0%)	21	(13.0%)	864,714.29	600,000.	855,357.69
	保険給付金(年)	229	386,723.14	0.	765,855.04	5,776,127	0	115	(50.2%)	114	(49.8%)	776,838.60	400,000.	935,497.83
Q10-1	年齢	388	56.07	55.	11.10	87	25	0	(0.0%)	388	(100.0%)	56.07	55.	11.10
Q10-2	がんと診断された時期 - "x年前"の回答	373	3.37	2.	3.29	22	1	0	(0.0%)	373	(100.0%)	3.37	2.	3.29

前立腺 - 全例 (576件中)

問番号	内容	すべての回答						"0"		"0" 以外			
		件数	平均	中央値	標準偏差	最大値	最小値			回答件数		平均	中央値	標準偏差
Q1-2	片道の通院時間	561	48.07	40.	41.67	450	2	0	(0.0%)	561	(100.0%)	48.07	40.	41.67
Q1-3	往復交通費 - 本人	393	1,933.39	1,000.	3,938.87	50,000	0	30	(7.6%)	363	(92.4%)	2,093.18	1,000.	4,057.39
	往復交通費 - つきそい	127	1,659.75	840.	3,078.69	20,000	0	27	(21.3%)	100	(78.7%)	2,107.88	1,100.	3,330.59
Q1-4	1ヶ月の通院回数	357	1.81	1.	3.01	26	0	1	(0.3%)	356	(99.7%)	1.81	1.	3.01
	1年間の通院回数	410	11.97	10.	16.11	200	1	0	(0.0%)	410	(100.0%)	11.97	10.	16.11
Q1-5	(現在も含め)これまで受診した病院・診療所の数	550	1.70	2.	0.79	5	0	9	(1.6%)	541	(98.4%)	1.73	2.	0.76
Q1-6	これまで入院した回数	522	1.32	1.	1.20	12	0	90	(17.2%)	432	(82.8%)	1.59	1.	1.14
Q1-7	昨年1年間の合計入院期間	458	10.78	3.	20.27	160	0	204	(44.5%)	254	(55.5%)	19.44	12.	23.93
Q4-1	入院分(月)	131	77,341.98	0.	187,815.95	1,450,000	0	81	(61.8%)	50	(38.2%)	202,636.00	90,000.	258,903.41
	外来分(月)	402	17,635.86	10,000.	24,368.12	210,000	0	39	(9.7%)	363	(90.3%)	19,530.62	11,050.	24,911.77
	入院分(年)	201	207,517.64	60,800.	283,379.28	1,200,000	0	54	(26.9%)	147	(73.1%)	283,748.61	200,000.	296,938.95
	外来分(年)	420	139,241.66	91,815.	199,486.69	3,000,000	0	21	(5.0%)	399	(95.0%)	146,570.17	100,000.	202,027.89
Q4-2	健康食品・民間療法(月)	305	15,161.90	3,000.	51,485.09	600,000	0	130	(42.6%)	175	(57.4%)	26,425.02	10,000.	65,743.35
	健康食品・民間療法(年)	352	162,031.48	20,000.	549,913.29	6,000,000	0	138	(39.2%)	214	(60.8%)	266,519.07	100,000.	685,248.33
Q4-3	その他の支出額(月)	196	1,753.65	0.	7,349.17	70,000	0	176	(89.8%)	20	(10.2%)	17,185.75	11,500.	16,250.82
	その他の支出額(年)	255	25,761.22	0.	90,491.20	1,000,000	0	183	(71.8%)	72	(28.2%)	91,237.65	48,640.5	151,748.40
Q4-4	保険料(月)	250	18,379.05	8,950.	28,021.24	220,000	0	73	(29.2%)	177	(70.8%)	25,959.11	15,000.	30,203.54
	保険料(年)	346	191,501.03	102,000.	251,193.25	1,680,000	0	75	(21.7%)	271	(78.3%)	244,499.46	150,000.	260,004.84
Q5-1	高額医療費として、戻ってきた金額	354	45,682.37	2,676.	115,628.02	1,200,000	0	167	(47.2%)	187	(52.8%)	86,478.93	29,900.	147,586.27
Q5-2	医療費還付として、戻ってきた税金	264	13,594.20	0.	41,782.11	400,000	0	193	(73.1%)	71	(26.9%)	50,547.44	30,000.	67,995.07
Q5-3	保険給付金(月)	218	24,118.47	0.	144,452.75	1,400,000	0	200	(91.7%)	18	(8.3%)	292,101.50	36,273.	417,659.48
	保険給付金(年)	317	176,309.80	0.	463,655.72	5,000,000	0	208	(65.6%)	109	(34.4%)	512,754.19	300,000.	672,825.36
Q10-1	年齢	574	71.83	72.	7.25	92	49	0	(0.0%)	574	(100.0%)	71.83	72.	7.25
Q10-2	がんと診断された時期 - "x年前"の回答	528	3.56	2.5	3.19	25	1	0	(0.0%)	528	(100.0%)	3.56	2.5	3.19