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P Caron France	S Gaberšček Slovenia	D Kastelan Croatia	J Mittag Germany	H Romijn The Netherlands	T Williams Italy
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H Cederberg-Tamminen Finland	L Gennari Italy	F Kelestimir Turkey	N Morton UK	M Ruchala Poland	B Yildiz Turkey
O Chabre France	R Gereben Hungary	R Kineman USA	A Mukherjee UK	E Rutten Belgium	J Young France
P Chanson France	A-P Gimenez-Roqueplo France	T Kocjan Slovenia	E Nagy Hungary	S Sankac Turkey	M Zarkovic Serbia
K Chatterjee UK	F Giorgino Italy	J Kopchick US	J Newell-Price UK	S Sanlioglu Turkey	M Zatliti Italy
F Chiarelli Italy	A Giustina Italy	M Korbonits UK	M Niedziela Poland	D Santi Greece	M-C Zennaro France
J Chowen Spain	J Gomez-Ambrosi Spain	B Kos-Kudla Poland	R Nogueiras Spain	P Saunders UK	C Zillikens Netherlands
S Christin-Maitre France	D Goulis Greece	C G Krausz Italy	B Obermayer-Pietsch Austria	C Schalin-Jäntti Finland	

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CONTENTS

21st European Congress of Endocrinology 2019

PRIZE LECTURES AND BIOGRAPHICAL NOTES

The European Journal of Endocrinology Prize Lecture	EJE1
The Geoffrey Harris Prize Lecture	GH1
European Hormone Medal Lecture	EHM1
Clinical Endocrinology Trust Lecture	CET1

PLENARY LECTURES

Designing Cities and Homes as Exercise Machines: Helping endocrinologists to fight metabolic disease	PL1
Genetic epidemiology of puberty timing and reproductive lifespan (<i>Endorsed by the European Journal of Endocrinology</i>)	PL2
Pancreatic beta-cell ageing: Novel mechanisms and consequences in the management of diabetes	PL3
Exercise Training in the Management of Type 2 Diabetes	PL4
Paracrine regulation of the adrenal cortex	PL5
Graves orbitopathy	PL6
Control of Integrative Physiology by the Melanocortin Circuitry	PL7

SYMPOSIA

Thyroid in cancer	S1.1–S1.3
Trends in puberty	S2.1–S2.3
Circadian clocks: from pathophysiology to chronomedicine	S3.1–S3.3
Immunology and endocrinology (<i>Endorsed by Endocrine Connections</i>)	S4.1–S4.3
Microbiota as new treatment for diabetes and metabolic disease	S5.1–S5.3
A better life with thyroid hormone (<i>Endorsed by the European Journal of Endocrinology</i>)	S6.1–S6.3
Endocrine disrupting chemicals (<i>Endorsed by Endocrine Connections</i>)	S7.1–S7.3
Genderdysphoria delayed puberty	S8.1–S8.3
Controversies in adrenal disease	S9.1–S9.3
Cancer drug-induced osteoporosis (<i>Endorsed by Endocrine Connections</i>)	S10.1–S10.3
EDCs & reproduction	S11.1–S11.3
Craniopharyngioma; a challenging tumour to treat and a difficult aftermath	S12.1–S12.3
Central control of metabolism: Brain rules all	S13.1–S13.3
Innovations in NETs	S14.1–S14.3
European Young Endocrine Scientists (EYES)	S15.1–S15.6
Thyroid in pregnancy	S16.1–S16.3
Where do pituitary tumours come from?	S17.1–S17.3
Congenital hypogonadotropic hypogonadism: New insights into GnRH Regulation	S18.1–S18.3
Adrenal insufficiency	S19.1–S19.3
News on nutrition: when to eat what	S20.1–S20.3
Rare bone disorders	S21.1–S21.3
The pituitary as metabolic sensor (<i>Endorsed by Endocrine Connections</i>)	S22.1–S22.3
PCOS: can we personalise treatment?	S23.1–S23.3
What's new in the Adrenal Cortex? (<i>Endorsed by the European Journal of Endocrinology</i>)	S24.1–S24.3
Late Breaking Session	S25.1–S25.3
Impact of thyroid disease on...	S26.1–S26.3
What's new in reproductive endocrinology?	S27.1–S27.3
Vitamin D - non-skeletal effects in RCT	S28.1–S28.3
Endocrine controversies in sport	S29.1–S29.3
Personalised medicine in diabetes and obesity (<i>Endorsed by the European Journal of Endocrinology</i>)	S30.1–S30.3
Special Symposium: ESE, the International Society of Endocrinology and the Endocrine Society Joint Session - Endocrinology of Aging	SS1.1–SS1.3

NEW SCIENTIFIC APPROACHES NSA1–NSA6

DEBATES

Food addiction in humans: to be or not to be? D1.1–D1.2
Surgical treatment of pheochromocytoma - query pre-treatment D2.1–D2.2
T4 is not enough D3.1–D3.2
Pituitary pathology: Do we care? D4.1–D4.2
MicroRNAs as hormones? D5.1–D5.2
Should we treat young osteoporotic patients? D6.1–D6.2

MEET THE EXPERT SESSION MTE1–MTE16
. EYIJC1

MEET THE BASIC SCIENTIST SESSION MTBS1–MTBS3

NURSE SESSION NS1.1–NS1.3
. MTNE1
. NPD1–NPD5

UEMS SESSION UEMS1.1–UEMS1.3

ORAL COMMUNICATIONS

Calcium and Bone OC1.1–OC1.5
Diabetes 1 OC2.1–OC2.5
Cushing’s and acromegaly OC3.1–OC3.5
Thyroid 1 OC4.1–OC4.5
Adrenal 1 OC5.1–OC5.5
Obesity OC6.1–OC6.5
Endocrine Connections 1 OC7.1–OC7.5
Reproduction 1 OC8.1–OC8.5
Thyroid 2 OC9.1–OC9.5
Adrenal 2 OC10.1–OC10.5
Diabetes 2 OC11.1–OC11.5
Endocrine Connections 2 OC12.1–OC12.5
Anterior and Posterior pituitary 2 OC13.1–OC13.5
Sex Hormones OC14.1–OC14.5

GUIDED POSTERS

Adrenal and Neuroendocrine - Tumour GP1–GP14
Calcium and Bone 1 GP15–GP25
Diabetes and Cardiovascular Disease GP26–GP36
Metabolic Syndrome and Hypoglycaemia GP37–GP47
Acromegaly and GH GP48–GP60
Reproductive Axis GP61–GP69
Thyroid Autoimmune Disorders GP70–GP81
Thyroid Nodules and Cancer GP82–GP93
Adrenal and Neuroendocrine - Basic GP94–GP106
Calcium and Bone 2 GP108–GP118
Diabetes: Late Complications GP119–GP129
Obesity GP130–GP141
Interdisciplinary Endocrinology 1 GP142–GP152
Cushing’s GP153–GP164
Obesity GP165–GP175
Benign Thyroid Disorders GP176–GP186
Adrenal and Neuroendocrine - Clinical GP187–GP199

Guided Posters

pHPT. The aim of our study is to evaluate the value of a second pre-operative ^{99m}Tc -MIBI in persistent sporadic pHPT and the interest of the adjunction of US. Patients and Methods

Fifty patients operated on between 2006 and 2016 in three French University Hospitals (Nantes, La Pitié Salpêtrière, Paris and Angers) were included in this study. All patients had a persistent sporadic pHPT after a first surgery and have been re-operated on. A ^{99m}Tc -MIBI was performed in each case before the first and the second operation. US was always performed before the first operation and in 43 patients before re-operation. The cure rate (following second ^{99m}Tc -MIBI and second surgery), the number of new pathologic localized glands, and the intrinsic properties of second ^{99m}Tc -MIBI to localize the side of an abnormal parathyroid gland were evaluated. Intrinsic properties of ^{99m}Tc -MIBI and US were also evaluated.

Results

Forty-two patients (84%) were cured after the second surgery. Among these, 31 (62% of the patients) had a gland removed on the area identified by second-MIBI. Twenty-six new pathologic glands (52%) were identified by second-MIBI, including 18 patients (36%) with a multiglandular disease and 8 patients (16%) with a negative first-MIBI. Overall intrinsic properties of the second-MIBI are 67% sensitivity (se), 91% specificity (sp), 82% positive predictive value (PPV) and 81% negative predictive value (NPV). Performing the second-MIBI one year or more after the first -MIBI provided important sp: 97% vs 86% when second-MIBI was performed in the first year, and PPV: 93% vs 77%, but with a decreased sensitivity (59% vs 71%) and NPV (79% vs 82%). Concordant second-MIBI and US (17 patients) had the better se (77%), 85% sp, 77% PPV and 85% NPV.

Conclusion

Performing a second ^{99m}Tc -MIBI leads to find new pathologic glands in more than 50% of the cases in sporadic pHPT, especially in multiglandular disease. The concordant couple ^{99m}Tc -MIBI and US is the most accurate examination to localize the side of an abnormal parathyroid gland before re-operation. When discordant, the ^{99m}Tc -MIBI performed more than one year after the first-MIBI has the best specificity and NPV.

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GP18

Calcium to Phosphorus (Ca/P) ratio as an accurate index for the diagnosis of primary hyperparathyroidism (PHPT) and hypoparathyroidism (HypoPT)

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Background

The diagnosis of PHPT and chronic HypoPT is still challenging, mainly due to the wide spectrum of clinical and biochemical presentation and the lack of validated diagnostic index in literature. The serum Ca/P ratio has been proposed as an accurate tool to diagnose PHPT in a small sample of patients, while no data is available about its possible application for HypoPT.

Aim

To validate the serum Ca/P ratio as a diagnostic index for PHPT and to investigate its diagnostic performance in the diagnosis of HypoPT by analyzing a large series of data coming from a multicenter study.

Methods

Multicenter, retrospective, case-control study, including 432 PHPT patients and 217 HypoPT patients, compared with 389 controls. Main outcomes: serum Ca, P, albumin, creatinine, parathyroid hormone (PTH) and 25-OH vitamin D (only for controls and PHPT). *Statistical analysis*: Comparisons among groups were performed by the nonparametric Kruskal-Wallis, followed by the Dunn's post hoc test. The diagnostic accuracy of Ca/P ratio was investigated by receiver operator characteristics (ROC) curves in order to define cut-off points (with the highest sensitivity and specificity).

Results

The Ca/P ratio was significantly different among groups, resulting higher in PHPT and lower in HypoPT patients than controls ($P < 0.0001$). At ROC curve analysis, the Ca/P ratio above 3.3 was defined for the diagnosis of PHPT (sensitivity 85.7%, specificity 85.3%), while the Ca/P ratio below 2.3 for the diagnosis of HypoPT (sensitivity 88.2%, specificity 87.9%). Considering the PHPT group, the cut-off of 3.1 for Ca/P was able to specifically identify patients with normocalcemic PHPT (sensitivity 80.3%, specificity 80.2%).

Conclusions

This study further validates the serum Ca/P ratio as a highly accurate diagnostic index for PHPT, defined by Ca/P above 3.3. For the first time, a Ca/P ratio below 2.3 is proposed to identify HypoPT patients. Our findings confirm the reliability of this index to screen and/or rule out disorders of Ca-P metabolism.

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GP19

18F-Fluorocholine PET/CT in patients with primary Hyperparathyroidism and negative or inconclusive ^{99m}Tc -MIBI parathyroid scan: clinico-pathological correlations

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Introduction

The gold standard for evaluating Occult Parathyroid Adenomas (OPa) in patients with biochemical pattern of primary hyperparathyroidism (PHPT) is the ^{99m}Tc -MIBI parathyroid scan. 18F-Fluorocholine (18F-FCH) PET/CT has been proposed as a potential technique for detection and localization of OPa when ^{99m}Tc -MIBI scan is negative or inconclusive.

Aims

To evaluate sensitivity and positive predictive value of 18F-Fluorocholine PET/CT in patients with biochemical PHPT with negative or inconclusive ^{99m}Tc -MIBI scan. To correlate 18F-FCH PET/CT findings with clinical and surgical characteristics.

Methods

We analyzed all subjects with biochemical PHPT attended in our department (January–December 2018) with a negative/inconclusive ^{99m}Tc -MIBI in which 18F-FCH PET/CT was performed. Patient characteristics, time of diagnosis of PHPT, serum calcium and parathyroid hormone (PTH) levels were recorded. In those patients who underwent parathyroidectomy, affected glands, type of surgery, postoperative serum calcium, PTH levels and pathological features were correlated with 18F-FCH PET/CT findings. Differences were considered significant for *ap value* < 0.05 . SPSS Statistics package was used for statistical analysis (Mann-Whitney, Chi-square and T student tests).

Results

A total of 23 subjects with biochemical PHPT with negative ($n=19$) or inconclusive ($n=4$) ^{99m}Tc -MIBI scan were included (74.47% female, 61.4 ± 14.7 years, time since diagnosis 24.7 ± 30 months, 17.4% with previous unsuccessful surgery, calcium 2.69 ± 0.18 mmol/l, PTH 21.75 ± 28 pmol/l, 3 subjects with MEN1 and 1 with familiar PHPT). 18F-FCH PET/CT was positive in 18 patients, negative in 4 and inconclusive in 1. No differences were found between subjects with positive and negative 18F-FCH PET/CT in the analyzed variables (a tendency to higher PTH was observed in subjects with positive 18F-FCH PET/CT ($P=0.057$)). Parathyroidectomy was performed in 12 patients (11 patients are pending of surgery), resulting in 10 cases a solitary OPa by pathology. OPa were located 6 in the left upper gland, 2 in the left lower gland and 2 in the right lower gland. 18F-FCH PET/CT localization was concordant with the excised OPa in all patients except for one case. In one case of failed surgery PET indicated an ectopic gland and in the other case a left low gland. Moreover, elevated preoperative PTH and serum calcium decreased 10 minutes after surgery.

Conclusions

In our series of patients with biochemical PHPT and negative/inconclusive ^{99m}Tc -MIBI parathyroid scan, 18F-FCH PET/CT offers greater sensitivity and precision during performance of parathyroidectomy (sensitivity 78.2%, positive predictive value 83.3%). No clinical or biochemical data was associated with PET positivity.

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Author Index

- Åkermann, A-K P431
 Aancute, A GP116
 Aas, FE GP181
 Abad, M P850
 Abad, RSdIC EP39
 Abainou, L P246
 Abbas, A P517 & P518
 Abd-Elraoof, M P768
 Abd-Elstar, H P768
 Abdallah, NB P49
 Abdelghani, T EP149
 & P351
 Abdelhak, S EP80
 Abdelkafi, M P202, P385
 & P88
 Abdelkarim Asma, B P368
 Abdelkarim, A P778
 Abdelkarim, AB P1086,
 P702 & P827
 Abdelkefi, M EP153,
 P1164, P1188, P395
 & P787
 Abdellaoui, W EP134
 & P683
 Abdelmonem, H P61
 Abderrahmane, S EP50
 & P159
 Abdoul, H P1017
 Abdulla, H P124 & P340
 Abdulladjanova, N GP206
 Abduvakhobova, M P238
 Abduvaliev, A P175
 Abe, H EP17, P31, P387
 & P92
 Abed, YHE P822, P886
 & P891
 Abeillon, J GP238
 Abel, ED S30.1
 Abid, M EP102, EP103,
 GP29, P1031, P1053,
 P1056, P1058, P1097,
 P1100, P1175, P1213,
 P556, P803, P805,
 P815, P834, P842,
 P844, P848 & P987
 Abiega, BU P347
 Abir, T EP107, P289
 & P290
 Abizanda, EP P1116
 Abizanda, JEP P869
 Aboromia, MM GP131,
 P122 & P61
 Abou Jaoude, M P211
 Abraham, A GP123
 Abrahamsen, B OC14.4
 Abreu, AP GP62
 Abribat, T OC6.1
 Abrosimov, A EP143
 & P15
 Abucham, J MTE16
 Abud, M EP20
 Acatrinei, E P13
 Accardo, G P319
 Acerini, C GP197
 Ach, K P1072, P1086,
 P1137, P702, P778,
 P779, P827 & P967
 Acha Pérez, J P959
 Acikgoz, A GP248
 Acitores, A P225
 Ackermann, D P570
 Acosta-Calero, C EP40,
 EP41, P853, P860,
 P932, P971 & P978
 Acuña Garcia, M P243
 Adachi, H P205
 Adamcová, K P316
 Adamcova, K P1142
 Adamidou, F P1158,
 P1163, P357, P467,
 P523, P851 & P889
 Adamsbaum, C OC7.3
 Adamska, P P1159
 Adana, MRd P184
 Adel, M EP120 & P425
 Adler-Cohen, C P750
 Adorni, MP GP69
 Aers, X OC14.2
 Afanasyev, D P104, P210,
 P389 & P540
 Afentoulidi, A P366, P367
 & P401
 Afshan, K EP3, P1160,
 P456 & P892
 Agachi, I P420
 Agapito, A EP101 & P716
 Agarwal, A EP158
 Agea, L P1134
 Aggarwal, A P489
 Aggeli, C GP9, P20
 & P877
 Agha, A P535, P696
 & P789
 Aghayan, M P653
 Aghayi, H P1215
 Aghlmandi, S P1013
 Agius, R EP129
 Agoulnik, A GP223
 Agoulnik, I GP223
 Agredos, ÁG-MV P1061
 Agrogannis, G OC2.4
 Aguayo, FJ P386
 Aguilar Diosdado, M P165
 & P167
 Aguirre Moreno, N P1106
 Aguirre, M P372
 Ahluwalia, R OC3.2
 Ahmad, F P124
 Ahmad, T P413
 Ahmadova, K P454
 Ahmed Kocçir, E P559
 Ahmed, F GP197
 Ahmed, R EP112
 Ahn, C P127
 Ahn, CW GP28, GP85
 & P583
 Ahn, JH P533
 Ahn, KJ P156
 Ahn, SV P90
 Ailloud, S P1148
 Aim, LB OC5.1
 Ainhua, I OC9.1
 Aja-Curbelo, VSd EP41
 Ajzenberg, C OC5.1
 Akalin, A P857
 Akalin, A P482
 Akay, OM P482
 Akbiyik, F P1024
 Akdemir, AY P816
 Akdeniz, Y P352
 Akdeniz, YS P28
 Akhrarova, N P572
 Akirov, A GP119
 Akkalp, AK P817
 Akkan, K P454
 Akkan, T P114, P496
 & P773
 Akkari, I EP73, P636,
 P650 & P883
 Akloul, L GP61
 Akram, M EP3, P1160,
 P456 & P892
 Aktas, A GP88 & P807
 Akulevich, N P1032
 Al Ghuzlan, A P433
 Al Salam, RA P300
 & P341
 Al Sebaei, H P473
 Al-Tawil, D P980
 Alagüney, ES P482
 Alam, SMK P136
 Alaminos, MEL GP183,
 P1224, P1225, P1227
 & P1229
 Albani, A GP156
 Albarel, F P288
 Albert, L P39, P527
 & P810
 Albisinni, S P812
 Alboim, S GP8
 Albu, A EP76, P1169,
 P1186, P304 & P479
 Albu, D P1169
 Albuquerque, I P906
 & P910
 Albuquerque, L P1093,
 P1113 & P1118
 Alcántara-Laguna, M-D
 P534, P576 & P581
 Alcántara-Laguna, MD
 P287
 Alcázar, V P746
 Alcaín-Martínez, G P609
 Aldabe, N P384
 Aldama, P P44 & P443
 Alday, IH P1216 & P946
 Aldiss, P S15.1
 Alduk, A-M P824
 Aleali, AM P131 & P132
 Aleknaite, A P1190
 Aleksandra Kravos, N
 GP247
 Alemañ, GB P529
 Aleric, I P447
 Alevizaki, M GP86 & GP90
 Alexander Wudy, S GP96
 Alexander, P P143, P145,
 P153 & P154
 Alexandra Hanzu, F
 P1107
 Alexandra, API P835
 Alexandraki, K P833,
 P873 & P877
 Alexandre, MI P699
 Alexandrescu, D P1065
 Alexiev, A P1012
 Alfano, S GP52, GP60,
 GP96 & P399
 Alfaqih, M P128
 Alfayate, R GP168
 & GP233
 Alfi, G P735
 Alfonso, AP GP233
 Alfonso, FJG EP122,
 GP209 & P1061
 Alhambra-Expósito, M-R
 P581
 Alhambra-Expósito, MR
 GP207 & P651
 Ali, H EP95

- Rindi, G P681
 Risovic, I P70
 Rittig, NF P209
 Rivadeneira, MEN P978
 Rivas, B GP223
 Rivero, DM EP32 & EP72
 Rivero, M OC5.2
 Riyad, SH P136
 Rizk-Rabin, M GP102, GP13 & OC10.4
 Rizados, D GP120, P140 & P217
 Rizvi, SSR EP3, P1160, P456 & P892
 Roa, J GP62, OC8.1 & OC8.4
 Robert, AA EP112
 Roberts, G UEMS1.2
 Robertson, D S20.2
 Robins, E P445
 Robledo, M S9.2
 Rocco, FD OC7.3
 Rocha, M P1146
 Rochira, V GP18, GP251, GP262, P255, P319 & P320
 Rodeberg, D P976
 Rodia, C P469
 Rodic, G P640
 Rodien, P GP231, OC4.4, P1000, P1001, P1049, P1198 & P639
 Rodionova, S P74
 Rodnikova, E P607
 Rodríguez Martín, A P167
 Rodrigues, A OC11.4
 Rodrigues, D EP104 & EP11
 Rodrigues, F P1165, P1191 & P875
 Rodrigues, M GP135 & P155
 Rodriguez, ARR OC9.2
 Rodriguez, DL OC8.3
 Rodriguez, IH P541
 Rodzik, B GP79
 Rogers, E P517 & P518
 Rogoziński, D GP240, P1077 & P1098
 Roh, E P176
 Rohban, T P451
 Rojbi, I P49 & P558
 Roldan, F P1087 & P1091
 Roli, L P320
 Rolighed, L P514
 Román, R GP34 & P793
 Román, DAdL P774
 Román, DDL P1226
 Romão, RÁ P493
 Roman, DDL EP148
 Romanelli, F P324 & P327
 Romanet, P GP152 & OC7.4
 Romano, E P1027
 Romanova, N EP143 & P15
 Romanowska-Próchnicka, K P579
 Romei, C GP263 & GP84
 Romero, A P766
 Romero, P P354
 Romero, SG P1043
 Romero-Lluch, A P746
 Romero-Pérez, E P609
 Romijn, H GP235
 Ron, E GP139
 Ronaldson, A OC13.3
 Ronan, K P1045
 Ronchi, C OC10.5
 Rontogianni, D GP9
 Roque, C EP117, P840 & P888
 Roque, J P701
 Roque, R P1219
 Roriz, RB P811
 Rosário, F P813
 Ros, E S20.3
 Rosa Alhambra Expósito, M GP93
 Rosa Gómez García, I EP88
 Rosa, M-P P181
 Rosas, AA P1227
 Rosas, KAA GP183 & P1224
 Rosenberg, A P235 & P976
 Rosenblum, RC P50 & P743
 Rosenwald, A OC10.5
 Roset, M P207
 Rosinha, P P906, P910 & P989
 Rosinski, B P1162
 Ross, I P437
 Ross, R GP197 & P664
 Rossi, E P681
 Rossi, L GP87
 Rossi, M GP87
 Rossi, R GP87
 Rossmann, H GP118
 Rosson, M P1101
 Rossoni, EA P196
 Rost, S OC10.5
 Rosu, A P498
 Roszkowska-Purska, K GP11
 Rotarescu, A P461
 Rothenbuhler, A GP150, OC7.3 & P492
 Rothman, JG GP15
 Rotin, D P284
 Rotkank, M GP215
 Rotman-Pikielny, P P107, P50 & P743
 Rottenburger, C GP226
 Rottstein, L P468
 Roualdes, V P655
 Rouf, S EP74, P110, P45, P46, P47, P537, P539, P575 & P683
 Roughton, M P734
 Roumeau, S P682
 Roumpidaki, Z P350, P383 & P678
 Rousseau, A GP245
 Rousselet, M-C P1049
 Rousselle, T P321
 Rovite, V P726
 Rovina, M P1002
 Rovite, V P52
 Roy, D P955
 Roy, M GP105
 Roy, P OC4.3
 Roy, T EP61, EP65, EP84, P125 & P63
 Rozhinskaya, L EP6, GP113, GP227, P1117, P74, P82 & P83
 Rrupulli, A EP140
 Ruas, L P1195, P929 & P947
 Rubin, B GP98
 Rubio, JA P354
 Ruchala, M GP182, GP184, P1204 & P796
 Rucz, K GP73
 Rudelli, CC OC12.4
 Rudina, L P197
 Rudkova, E P273
 Rudofsky, G GP137
 Ruffilli, F P60
 Ruggeri, RM GP178 & GP70
 Ruiz Pérez, E OC4.1
 Ruiz, IM P347
 Ruiz, MLG P1225
 Ruiz, S P1179
 Ruiz-Castañe, E GP250
 Ruiz-Pino, F GP62, OC8.1 & OC8.4
 Rumjantsev, P P74
 Rummakko, P P667
 Rumyantsev, P P116, P423 & P82
 Runkle, I P111, P649 & P850
 Ruohonen, S OC8.1
 Rusalenko, M EP126, P173, P213 & P305
 Ruscica, M GP69
 Rusinek, D P1161
 Russ, G EP150
 Russell, G P426
 Russo, G GP187
 Russo, L GP50, P1101 & P256
 Ruth, D P360
 Ruvio, G P441
 Ruyven, Lv OC12.1
 Ryan, C P789
 Ryan, NK P1156
 Ryu, HG P9
 Ryu, O-H P219
 Ryzhkov, A GP160
 Ryzhkova, D GP160
 Rzepka, E P841
 Šimoniene, D P495 & P961
 Świrska, J EP13 & P455
 Šrámková, M P605
 Šimonienė D, EP49
 Šeda, O P896
 Šedová, L P896
 S Lima, B EP89
 Sáez-Martínez, P OC12.3 & OC5.3
 Ságová, I P93
 Sánchez, BL GP183, P1225, P1227, P1229 & P174
 Sánchez, CM P1216 & P946
 Sánchez-Barbie, P712
 Sánchez-Ortiga, R GP233
 Sánchez-Pernaute, A P957
 Sánchez-Sánchez, R OC5.4
 Sánchez-Tapia, MJ GP62
 Sági, Z P861
 Sárman, B P861
 Sævik, B GP190 & P431
 Sérgio, J P186
 Sónia, A P670
 Søndergaard, E EYIJ1
 Saafi, W P1175