was better correlated to LVEF compared to D1 (r=0.28, p=0.02) and D7 (r=0.44, p<0.0001). In contrast, D1 and D7 lacked sensitivity in patients with HF. After adjustment for age, EF and E/A in multivariate analysis, EF<40, RVm correlated significantly negatively correlated with NT-proBNP (r=-0.6, p<0.0001). In patients with EF<40 results were: RVm 204±7, MAM 6.9±1.5, EF 49±6, Vp 37±13, A/Ea 8.9±0.3, DT 212±60, and NT-proBNP 565±79. Patients with EF<40 showed a significant correlation between RVm and MAM (r=0.6, p<0.001), Vp (r=0.4, p=0.05), E/A (r=0.3, p=0.05), and NT-proBNP (r=0.6, p<0.001). In patients with EF>40, RVm correlated significantly with MAM (r=0.5, p<0.001), E/A (r=0.4, p=0.005) and NT-proBNP (r=0.4, p=0.01). A multivariable linear regression analysis was used to test the independent predictive power of RVm and other variables on NT-proBNP levels in patients with HF. After adjustment for age, EF and E/A in multivariate analysis, RVm was inversely associated with plasma natriuretic peptide levels (adjusted r square 0.5, p<0.001). When we performed the same analysis in the subgroup of HF patients with EF<40, we found an adjusted r square 0.4, p=0.001 when RVm.