who are unresponsive or resistant to diuretics. However, its efficacy and safety remain unknown. We systematically reviewed the available randomized data on the efficacy and safety of UF in ADHF.

Methods: MEDLINE, EMBASE and the Cochrane Central Register of Controlled Trials (CENTRAL) were searched in January 2013 to identify Randomized Controlled Trials (RCTs) evaluating UF in ADHF patients. Outcomes of interest included net fluid loss, net weight loss, all-cause mortality, all-cause rehospitalization and adverse events. A random-effects model was used to calculate mean differences (MDs) and odds ratios (ORs) for continuous and dichotomous data, respectively, with 95% Confidence Intervals (CIs). Statistical heterogeneity was assessed by I² statistic (25% ≤ I² ≤ 75% for low, moderate and high heterogeneity, respectively).

Results: Eleven studies enrolling 614 participants were included in systematic review and data of ten (n=604) studies were meta-analyzed. A total of 302 (50%) participants were randomized to UF. Comparison arms consisted of intravenous diuretics (6 studies), no treatment (2 studies) and unspecified conventional therapy (2 studies; “standard HF therapies” and “conventional management”). Compared to control, treatment of UF was associated with significant net fluid loss (MD 1.43, 95% CI 0.51-2.35, P=0.002) and net weight loss (MD 1.64, 95% CI 0.04-3.34, P=0.04), with moderate to substantial statistical heterogeneity across studies (I²=50% and 70%, respectively). There were no significant differences in all-cause mortality (OR 1.08, 95% CI 0.63-1.86, P=0.77) or all-cause rehospitalization (OR 0.89, 95% CI 0.39-2.00, P=0.77). Analysis of adverse events was inconclusive since only one study reported event numbers.

Conclusions: Our meta-analysis shows that the use of UF is effective in reducing fluid and body weight, with no significant benefit in mortality or rehospitalization. Available randomized evidence on the effects of UF in ADHF is limited and underpowered. Data from well-conducted randomized clinical studies of adequate power are much needed to establish the role of UF in ADHF patients for whom conventional HF treatment is unsuccessful or contraindicated.

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MitraClip and CRT: who responds in real life? A comparison with Immanuel Klinikum, Bernau (Berlin), Germany

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Background: The MitraClip implantation as treatment of severe mitral regurgitation (MR) in congestive heart failure patients is often correlate with ventricular asynchrony resulting in a overlap with CRT. Unfortunately this overlap also often explain a non-responds with high mortality of both treatments. We were interested in a comparison our patients with this conditions to the predicted mortality of Seattle Heart Failure Model (SHFM).

Methods: We analyzed all patient with MitraClip implantation in our center from March 2009 to January 2013. 33 patient of them had additionally prior or after the MitraClip procedure a CRT implantation (5 0/28 °, UEF 25±13%). The mean follow up interval until January 2013 was calculated 34±6.4 month for CRT and 13±7.1 month for the MitraClip.

Results: The mean time interval from CRT to MitraClip was encloled 28 month (from 26 to 65 month). In all 33 patient we analyzed 8 suboptimal LV lead positions. The mean time interval from CRT to MitraClip was 28 month ±7.1 month for the MitraClip.

Conclusion: The MitraClip implantation in CRT patient is feasible and safely but the mortality in this particular cohort stay high. Particular patients with the clinical severe MR regurgitation respond significantly compared to patients with structural MR. The mortality of our patients is lower than calculate with the SHFM.