**RADIOFREQUENCY ABLATIVE MODIFICATION OF THE AV NODE FOR THE TREATMENT OF ATRIAL FIBRILLATION: EXPLORING THE VALUE OF AN OLD TECHNIQUE**

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Curative pulmonary vein isolation (PVI) with or without atrial substrate modification using radiofrequency, cyrothermal, and laser technologies is useful, but an incompletely effective, complex and costly approach to the treatment of atrial fibrillation. Alternatively, with its appeal of direct simplicity, palliative ablation of the AV node with pacemaker implantation provides many of the advantages of curative ablation including rate control, regular R-R intervals and symptom relief. Despite its direct simplicity and relative ease, the potential negative consequences of complete AV nodal ablation include obligate pacemaker therapy bringing with it required intensified follow-up, device complications, and usually, ventricular dyssynchrony. The advantages of offsetting the potential deleterious consequences of ventricular dyssynchrony with CRT and His-Bundle pacing are themselves offset with their own increase in costs, complexities and complications. Prior to the advent of pulmonary vein isolation nearly 2 decades ago, many investigators successfully explored the utility of partial AV nodal modification without obligate pacing to address both the symptoms and negative physiologic consequences of atrial fibrillation. Beyond the now accepted “traditional” invasive approaches to atrial fibrillation (curative ablation and AV node ablation-CIED), an intermediate third way in the invasive care pathway of patients with atrial fibrillation should be re-explored that includes AV nodal modification without CIED therapy. Beyond the work of investigators 2 decades ago, newer mapping techniques and a refined understanding of the AV nodal inputs should allow outcomes with high clinical success rates, low complications and diminished costs in the treatment of many patients with atrial fibrillation. Importantly, this intermediate “third way” approach in the care pathway does not preclude proceeding on to either curative ablation or fully palliative complete AV nodal modification with CIED therapy.