were to community OT, district nursing and home help. Dependency, most commonly trauma-related, was found in 50% and in most proved transient. Commonest referrals were to community OT, district nursing and home help. Refusal rates were high. Intervention patients received more services and were significantly (p = 0.027) more independent in instrumental ADL's such as shopping and cooking at follow-up. HV assessment was seen as helpful. There were no important differences in re-admission rates.

Study data was used to derive by means of multiple regression analysis an 8-point questionnaire to identify patients vulnerable on discharge from an AED. This study further defines the problems faced by elderly patients going home from an AED, demonstrates the value of HV intervention for the frailest and offers a means of identifying them prior to discharge.

The prevalence of carotid sinus syndrome (CSS) is an important but often overlooked cause of unexplained falls and syncope in the elderly and is diagnosed when carotid sinus massage (CSM) produces cardioinhibition (CI: > 3s asystole) or vasodepression (VD: > 50mmHg fall in systolic blood pressure) with carotid sinus massage (CSM). CI results from vagal excess and is abolished by atropine, allowing definition of the VD component. The aim of the study was to define the dose of atropine required to abolish (a) the heart rate (HR) slowing in response to 5s CSM (b) the HR response to the Valsalva manoeuvre (VM) and (c) salivary gland flow (SGF) in patients with CI CSS.

10 patients (9 male; mean age 72 years) with reproducible CI were studied. Patients had a mean of 6 (1-20) syncopal episodes. HR responses to CSM and VM (surface ECG) and SGF (change in weight of dental rolls placed in mouth for 1 min) were recorded at baseline and after consecutive bolus doses of atropine (25, 50, 75, 100, 150 and 300mcg), given intravenously to a cumulative dose of 700mcg.

Cardioinhibition was abolished in all patients with a total dose of 700mcg and in 80% with 400mcg. The pattern of inhibition of CI was biphasic. The HR ratio during VM did not vary significantly with increasing doses of atropine. The decline in SGF was evident earliest, at 75 mcg.

For clinical application, 700mcg of atropine will abolish the diagnostic cardioinhibitory response to carotid sinus massage in patients with the syndrome and allow for definition of the pure vasodepressor response.