

The UK's first neuroinclusive GP learning platform, with everything in one place.

Every picture in this book is the real product, taken from the live site. Tap any line below and it opens that page, and every page has a way back.

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Reviewed and updated by practising UK GPs, overseen by a Clinical Advisory Officer. No ads, no pharma money.

September 2026

TRY IT FIRST

Seven days of GPAtlas Premium, free.

Cancel any time inside the week and you pay nothing. Start the trial whenever you are ready.

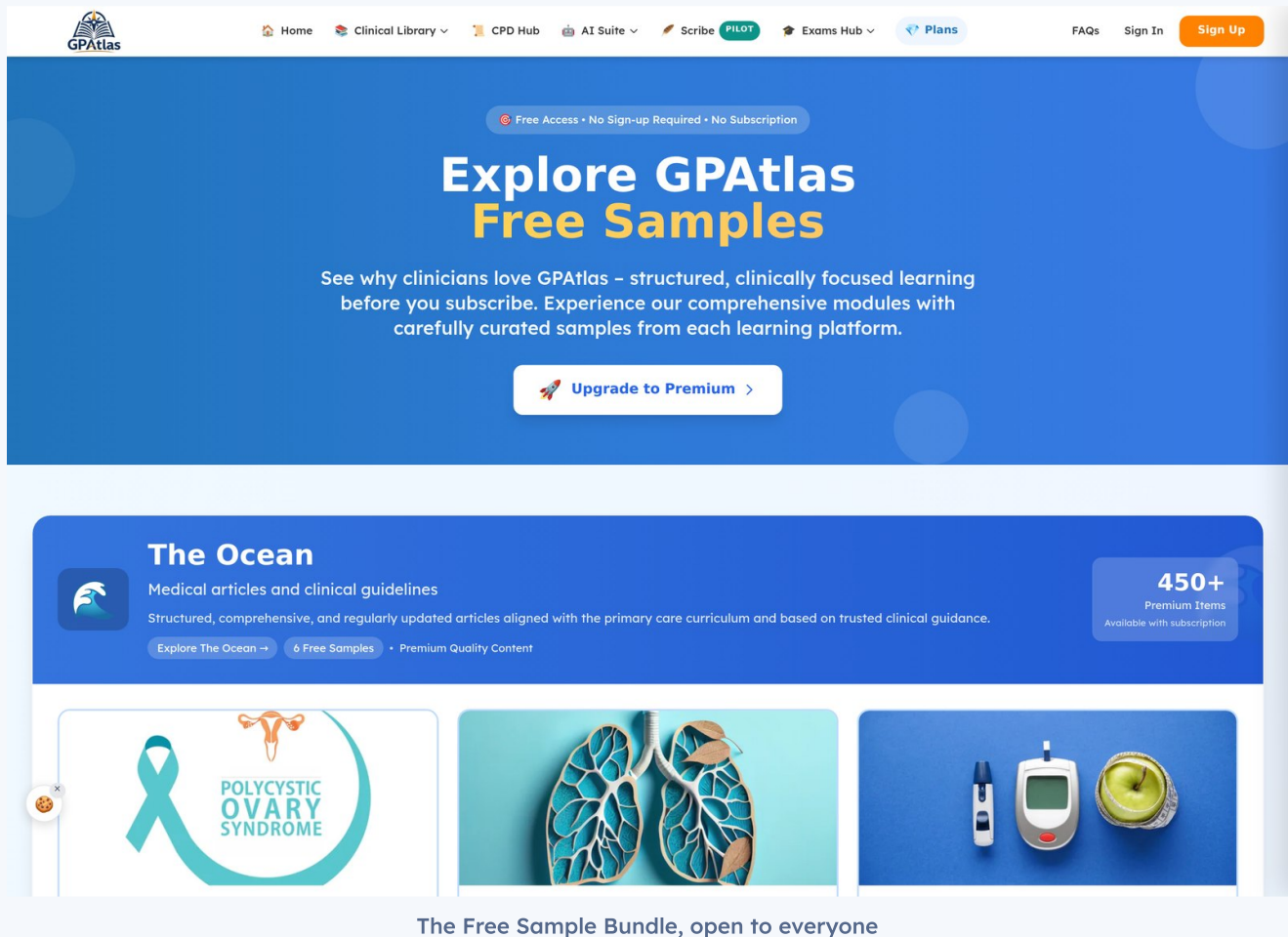
gpAtlas.co.uk/subscription



Everything you can use without paying a penny.

A free account opens more of GPAtlas than most platforms sell.

gpAtlas.co.uk/free-samples



The screenshot shows the GPAtlas website interface. At the top is a navigation bar with links for Home, Clinical Library, CPD Hub, AI Suite, Scribe (PILOT), Exams Hub, and Plans. There are also links for FAQs, Sign In, and a Sign Up button. Below the navigation bar is a large blue banner with the text 'Explore GPAtlas Free Samples'. The banner includes a sub-header 'Free Access • No Sign-up Required • No Subscription' and a paragraph: 'See why clinicians love GPAtlas – structured, clinically focused learning before you subscribe. Experience our comprehensive modules with carefully curated samples from each learning platform.' There is a button labeled 'Upgrade to Premium'. Below the banner is a section titled 'The Ocean' with a sub-header 'Medical articles and clinical guidelines'. It describes the content as 'Structured, comprehensive, and regularly updated articles aligned with the primary care curriculum and based on trusted clinical guidance.' There are buttons for 'Explore The Ocean', '6 Free Samples', and 'Premium Quality Content'. A badge indicates '450+ Premium Items Available with subscription'. Below this section are three image placeholders: one for Polycystic Ovary Syndrome, one for lungs, and one for a blood glucose meter and a green apple.

The Free Sample Bundle, open to everyone

WHAT IS IN IT

- **The Monday email.** This Week in UK Guidance, every Monday: what changed in UK guidance last week, in one short read.
- **The podcast, Clinical Rounds.** One clinical scenario worked through out loud by Sarah and Ben, about twenty minutes.
- **Every clinical topic opens for you.** The first section of every Ocean topic, plus the Free Sample Bundle.
- **The calculators.** Wells, FIB-4, CHA2DS2-VASc and more, each result explained.
- **The SCA.** A free mini mock with the marking sheet, a free dilemma chapter, and two spoken AI consultations.
- **The AKT.** Mock 1 in full, free sample questions, and free teaching notes with their spoken walkthroughs.

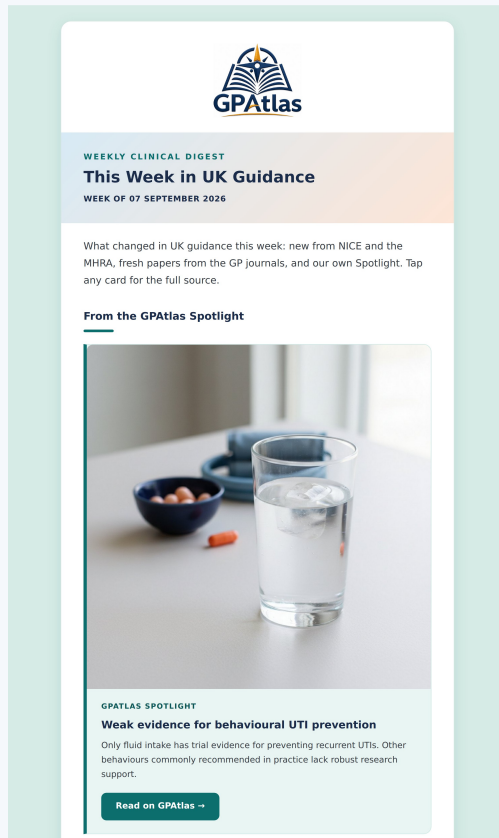
INSTEAD OF

paying before you know whether it is for you

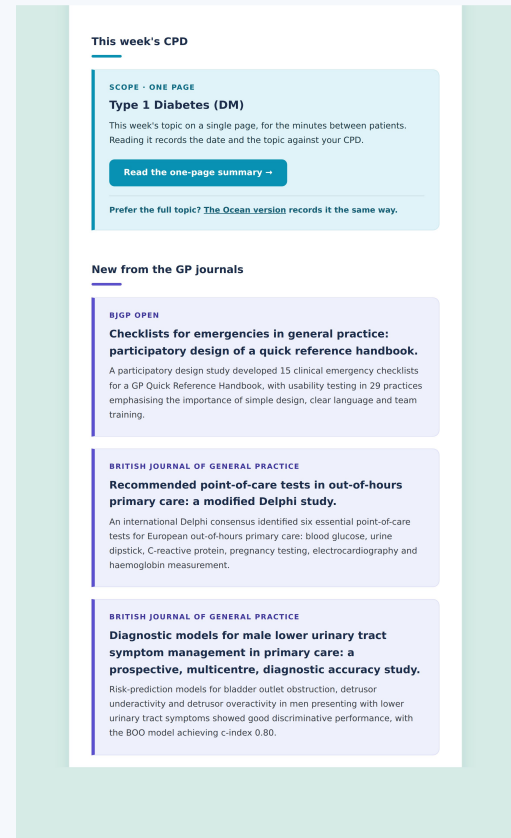
The week's changes, before a patient asks you about them.

A free email, every Monday: what changed in UK guidance last week, in one short read.

gpatlas.co.uk/week-in-uk-guidance



The email itself, as it lands on a Monday morning, dated to the week it covers



Inside it: this week's one page CPD topic, then the new papers worth knowing from the GP journals

WHAT LANDS IN YOUR INBOX

- A free account is the whole price. No card is asked for, at any point, and there is an unsubscribe link at the bottom of every one. Stop it whenever you like and the page stays open to you anyway.
- One read instead of five newsletters. What is new from NICE and the MHRA, the papers worth knowing from the GP journals, and our own Spotlight, gathered into a single Monday email.
- A one page CPD topic every week, and reading it records the date and the topic against your CPD without you typing a word.
- It points, it never prescribes. Every card opens the publication it came from. It is there so you hear early, not to tell you what to do.

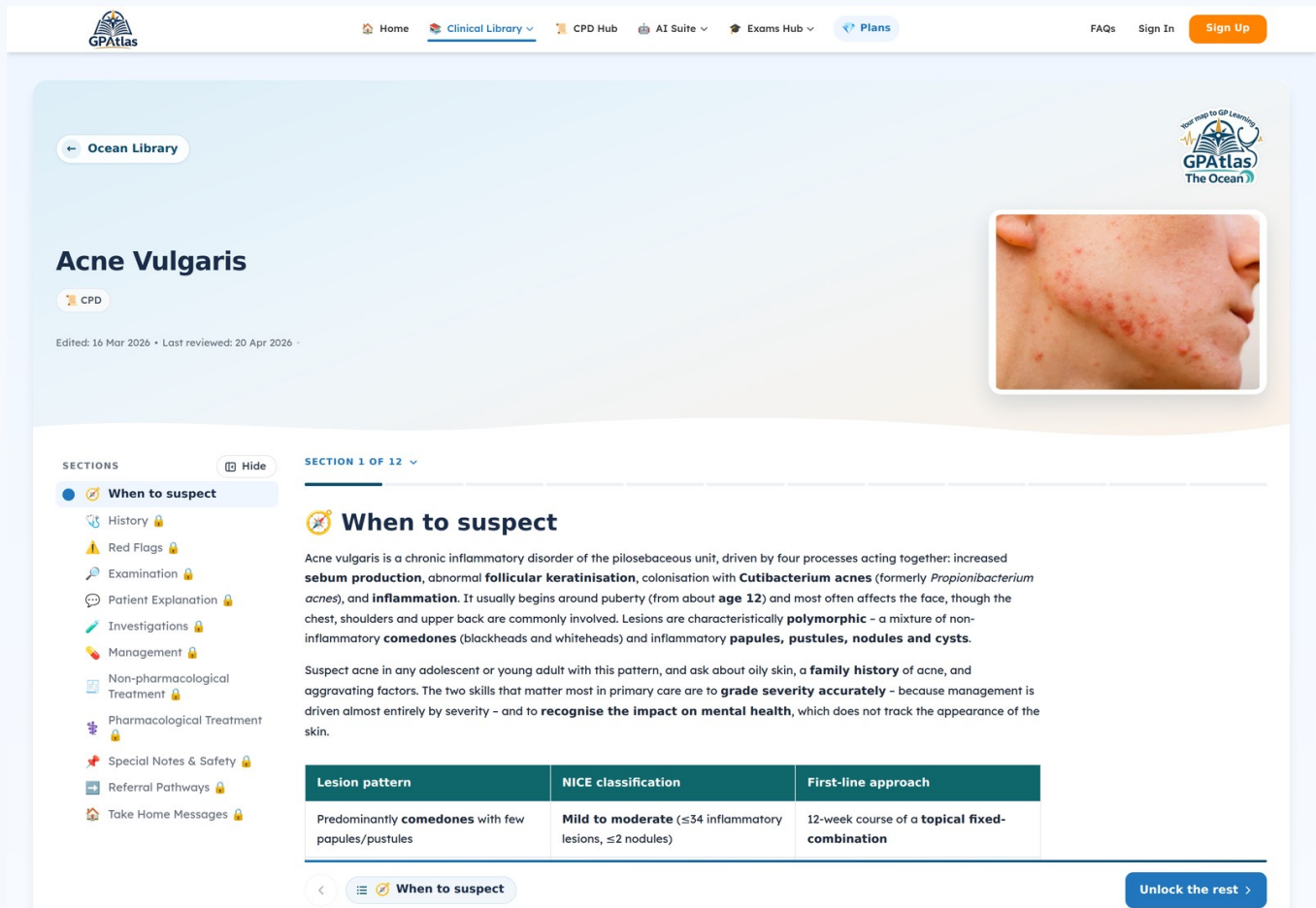
INSTEAD OF

missing a guideline change for months, or a safety alert long after it went out

The answer while the patient is still in the room.

Study once, not twice: the same 450+ topics answer the patient in the room and the MRCGP exams.

gpatlas.co.uk/ocean



Lesion pattern	NICE classification	First-line approach
Predominantly comedones with few papules/pustules	Mild to moderate (≤34 inflammatory lesions, ≤2 nodules)	12-week course of a topical fixed-combination

A topic page: contents down the side, the dates under the title, the CPD chip

1 One order, every topic

Every topic runs from when to suspect it through to referral, in the same order every time. The first section is free to everyone.

2 CPD in one click

Finish a section, click Mark Section Complete, and the credit is in your CPD Hub. Nothing to type.

3 At a glance ✨

One tap on that pill opens a short digest of the article, weighted to management and prescribing, for when the patient is already waiting.

Reviewed and updated by practising UK GPs, dated on every page, and in the same order every time, so what you read on a Tuesday between patients is the same reading that answers the exam.

INSTEAD OF

hunting through a dozen guideline tabs

Forty seconds, not four minutes.

Every common condition on one page: for the minutes between patients, and for the night before the exam.

gpatlas.co.uk/scope

ASTHMA

gpatlas.co.uk

Provide a Personalised Asthma Action Plan (PAAP) | Treat with ICS/formoterol as maintenance and reliever (MART) | Refer for diagnostic uncertainty or poor control

When to Suspect

Episodic **wheeze, cough, breathlessness**, or **chest tightness**, often worse at **night** or with **triggers** like **viral infections, allergens, or exercise**

Assessment

- **Symptoms + triggers** → Episodic **wheeze, cough, shortness of breath, chest tightness**; triggered by **viruses, allergens, exercise, NSAIDs**
- **Risk factors/history** → **Personal or family history of atopy (eczema, rhinitis), occupational exposure (baker, welder), smoking**
- **Impact + mimics** → Affects **sleep, work, and quality of life**; mimics: **COPD, GORD, heart failure, dysfunctional breathing**
- **Exam findings** → **Expiratory polyphonic wheeze** and signs of **atopy (nasal polyps, eczema)**; may be normal between episodes

Management

- ◆ **Key tests:**
 - **Spirometry + BDR, Fractional exhaled Nitric Oxide (FeNO), peak flow variability (2-4 weeks), blood eosinophils, CXR** to exclude others
- ◆ **Lifestyle:**
 - Provide **Personalised Asthma Action Plan (PAAP)**, advise on **trigger avoidance, smoking cessation, weight management**
- ◆ **Pharmacological:**
 - **Adults (≥12y):** Step 1: As-needed **low-dose ICS/formoterol reliever** → Step 2: **Low-dose**

Red Flags

- **Life-threatening attack** → **PEFR <33%, SpO₂ <92%, cyanosis, exhaustion, silent chest**
- **Acute severe attack** → **PEFR 33-50%, RR ≥25/min, HR ≥110/min, unable to complete sentences**
- **Fever with purulent sputum**
- **Unexplained weight loss or persistent hoarseness**
- **In children** → **Symptoms from birth, failure to thrive, excessive vomiting**

Referral Criteria

- Urgent:** **Acute severe or life-threatening attacks; children with symptoms from birth, failure to thrive, or vomiting**
- Routine:** **Diagnostic uncertainty, suspected occupational asthma, poor control on Step 4 (adults) or Step 3 (children) treatment**

GP Tips

- ◆ **Poor inhaler technique** and **adherence** are the most common reasons for treatment

160+ one page infographics, distilled from their Ocean topics by the same practising UK GPs. Your CPD logs itself as you read.

INSTEAD OF crib sheets that quietly go out of date

Your commute becomes the reading you never get to.

500+ audio summaries and deep dive podcasts, each the companion of a topic in The Ocean.

gpatlas.co.uk/echo

Audio Summaries 463

Podcasts 75

 GIT gpatlas.co.uk Gastroenterology (GIT) 32 audios 1 free Aug 2026	 MUSCULOSKELETAL gpatlas.co.uk Musculoskeletal (MSK) 34 audios 1 free Jun 2026	 NEUROLOGY gpatlas.co.uk Neurology 22 audios 1 free Aug 2026	 PAEDIATRICS gpatlas.co.uk Paediatrics (Children's Health) 55 audios 1 free Aug 2026
 PREVENTIVE MEDICINE & SAFEGUARDING gpatlas.co.uk Preventive Medicine & Safeguarding 9 audios 1 free Jul 2026	 WOMEN'S HEALTH gpatlas.co.uk Women's Health 25 audios 1 free Aug 2026	 ALLERGY & IMMUNOLOGY gpatlas.co.uk Allergy & Immunology 8 audios May 2026	 CARDIOVASCULAR gpatlas.co.uk Cardiovascular 26 audios Aug 2026
 DERMATOLOGY gpatlas.co.uk Dermatology 38 audios Aug 2026	 DRUG & ETHICAL DILEMMAS gpatlas.co.uk Drug & Ethical Dilemmas 18 audios Apr 2026	 ENT gpatlas.co.uk ENT 19 audios May 2026	 ENDOCRINOLOGY gpatlas.co.uk Endocrinology 17 audios Aug 2026
 GENETICS & HEREDITARY CONDITIONS gpatlas.co.uk Genetics & Hereditary Conditions 13 audios Mar 2026	 HAEMATOLOGY gpatlas.co.uk Haematology 6 audios Apr 2026	 INFECTIOUS DISEASES gpatlas.co.uk Infectious Diseases 11 audios May 2026	 MALIGNANCY & CANCER gpatlas.co.uk Malignancy & Cancer 20 audios May 2026

Every chapter of the curriculum in your ears, two to three minutes a topic, one commute at a time. Your CPD logs itself as you listen.

INSTEAD OF paying separately for audio learning

The result on the screen, and what to do about it.

Lab results and antimicrobials, drawn as infographics: every threshold with its number and its unit, and the antibiotic decision, one sheet each.

gpatlas.co.uk/reference-sheets

Potassium out of range: high or low

Potassium out of range. The number that means today, and the one that means a repeat.

Last reviewed: 25 Oct 2025

Potassium out of range: how urgent, and is it real?

What normal looks like in an adult

Potassium	· 3.5 to 5.3 mmol/L, some laboratories 3.5 to 5.0
High	· 5.5 to 5.9 mild · 6.0 to 6.4 moderate · ≥ 6.5 severe
Low	· 3.1 to 3.4 mild · 2.6 to 3.0 moderate · ≤ 2.5 severe
Magnesium	· 0.7 to 1.0 mmol/L
All values serum.	

Same day, whatever else is going on

- $K \geq 6.5$ mmol/L, symptoms or none
- K 6.0 to 6.4 mmol/L with AKI* or acutely unwell
- $K \leq 2.5$ mmol/L
- Any level with ECG change, weakness or syncope

Yes

Admit for
immediate
assessment

No

A Labs sheet: potassium out of range, what normal looks like and what needs action today

WHAT IS IN IT

- **Labs.** A result comes back and you want to be sure. One sheet per question: what normal looks like, what needs action today, what can wait, and what to do next.
- **Antimicrobials.** Treat now, a back-up prescription, or none: the antibiotic decision on one sheet, with what to give if you do, at the moment you need it.
- **Calculators.** Wells, FIB-4, CHA2DS2-VASc and more, each result explained rather than just printed. Free to everyone.

INSTEAD OF

digging out the handbook for one threshold

It shows you where the answer came from.

Current UK guidance with its sources beside the answer, built for primary care.

gpatlas.co.uk/ask-expert

● Answer ready

 **Ask Expert**

searches live UK guidance, then answers

72-year-old man with type 2 diabetes, CKD stage 3b (eGFR 34) and heart failure with reduced ejection fraction, on metformin, ramipril and furosemide, HbA1c 74 and worsening ankle oedema. How should I optimise his treatment?

 **Moderate renal impairment detected (eGFR 34). Drug choice, dosing, and safety may differ significantly from standard prescribing. Check current BNF renal guidance before prescribing, and consider specialist advice where uncertainty remains.**

 **Guidance in brief**

- NICE NG203 and associated diabetes management algorithms recommend that for patients with **type 2 diabetes, CKD stage 3b (eGFR 34), and heart failure with reduced ejection fraction (HFrEF)**, treatment optimisation requires a coordinated approach to glycaemic control and cardiovascular stability [1](#) [4](#) [5](#).
- Metformin** use is restricted by **eGFR** thresholds, and **SGLT2 inhibitors** are recommended as a foundational therapy for **HFrEF** and **CKD** progression, provided the **eGFR** is within the licensed range [1](#) [4](#).
- Diuretic** therapy and **ACE inhibitor** dosing require adjustment based on **fluid status, potassium levels,** and **renal function** to manage **ankle oedema** and prevent further decline in **eGFR** [2](#) [3](#).

 **Points to consider**

- NICE NG203 frames the management of **type 2 diabetes** in the presence of **CKD stage 3b** as requiring careful monitoring of **eGFR** and **potassium** when using **ACE inhibitors** like **ramipril** [1](#).
- The presence of **HFrEF** with **worsening ankle oedema** suggests a need to evaluate the adequacy of **furosemide** dosing and the patient's current volume status, as well as the potential for **ACE inhibitor**-related fluid retention or renal impairment [2](#) [3](#).

A real answer: the question, then guidance in brief with every statement numbered to its source

1 Ask in your own words

Type it, dictate it, or attach a document.
Identifiers are removed automatically
and files are never saved.

2 A live search, not a memory

It searches current UK guidance live, trusted UK publishers first, and answers only from what it has just retrieved. It never invents a reference.

3 You check, you decide

Every statement is numbered to its source. You always hold the clinical decision.

Unlike a general chatbot, it does not draw on the open internet or invent a reference: every line comes from current UK guidance, with its source beside it. **GPAtlas includes an MHRA Class I registered medical device**. The evidence standard behind it is published, with how it compares with general chatbots: gpAtlas.co.uk/ask-expert-evidence.

INSTEAD OF

trusting AI that cites nothing

The evening work, done before you leave.

Referrals, A&G requests, patient letters and messages, drafted from the shorthand you already use.

gpatlas.co.uk/admin-copilot

1
2
3
Patient SMS with a verified NHS link
Draft ready

Admin Copilot
rough note in, ready-to-send document out

Never enter patient-identifiable information.

sms patient started sumatriptan 50mg for migraine attacks

DRAFT · PATIENT SMS

We have started you on sumatriptan 50mg. Please take one tablet at the start of a migraine attack.

Please contact us if your headaches become more frequent, the tablets do not help, or you feel dizzy or drowsy after taking them.

If you have a sudden severe headache, weakness on one side, or difficulty speaking, call 999.

You can read more about migraine on the NHS website (www.nhs.uk/conditions/migraine/).

Verified NHS link

The AI writes plain nhs.uk; GPAtlas swaps in the exact page from its checked directory of verified NHS links. If no verified page exists, the sentence is removed entirely. Never fabricated.

Copied

Edit

Referrals · A&G · SBARs · patient SMS · letters

A patient message drafted from a one line note, with the NHS link written in

WHAT IT CAN DO

- **Referrals and A&G requests.** Your shorthand becomes a complete letter: every abbreviation expanded, nothing invented.
- **Patient messages and letters.** The exact NHS page for that condition or medicine written in, and safety net advice at the end.
- **Clinical notes, SBARs, fit notes, home visits.** Tap the task, type your note, generate. Then read, tweak and send.

“Running online triage, Admin Copilot drafts my referrals and patient messages in seconds, and it even attaches the right NHS patient information leaflet. I just read, tweak and send.”

RK, GP Partner

INSTEAD OF

unpaid evenings writing referrals and letters

Your scribbled note, turned into an entry you are proud of.

Coaching that thinks the case through with you, the way a good educational supervisor would.

gpatlas.co.uk/portfolio-appraisal-hub

Portfolio Hub
Thinking with you

CCR
CPD
LEA / SEA
QIA

2 · THINK TOGETHER

The Hub

That is a clear presentation, and pausing to investigate rather than treat was a thoughtful call. To shape a strong entry, tell me a little more:

- What in her history or examination stood out to you?
- What made you reconsider empirical bisoprolol and investigate first?
- What was the most valuable part of your discussion with your senior?

You

She lives alone, with a background of HTN on ramipril, and a smoker, so a CXR felt essential given her smoking history, and pro-BNP to help rule out cardiac causes.

Think Together: it asks what a good educational supervisor would ask, and you answer

Portfolio Hub
Entry ready

CCR
CPD
LEA / SEA
QIA

4 · YOUR PORTFOLIO ENTRY, IN FULL

Title

New exertional breathlessness: diagnostic approach in older smoker

Brief description of key learnings

Reviewed a woman in her 60s presenting with two weeks of new exertional breathlessness, bibasal crackles, and oxygen saturations of 94% on air. Her background included hypertension on ramipril, and she was a smoker living alone. Initially, I considered empirical bisoprolol, but after pausing and discussing with a senior colleague, the plan was revised to investigate first with BNP, ECG, and CXR, with a review in one week. This case highlighted the essential role of CXR given her smoking history and the importance of pro-BNP in differentiating causes of breathlessness.

Clinical Experience Groups

Older adults including frailty and/or people at end of life

People with long-term conditions including cancer, multi-morbidity and disability

Capabilities

Making a diagnosis / decision

Data gathering and interpretation

Working with colleagues and in teams

Making a diagnosis / decision

I initially considered empirical treatment but paused to reflect on the need for further investigation. My decision to pursue BNP, ECG, and CXR first, informed by senior discussion, demonstrated a considered approach to diagnosis rather than immediate symptomatic treatment.

Entry ready: title, learning, capabilities and reflection, from your own answers

Nothing is invented. The entry is built only from what you tell it, mapped to the RCGP capabilities, and every word stays yours to edit.

WHAT IT WRITES WITH YOU

CCR	Clinical Case Review
CPD	CPD and supporting documentation
LEA / SEA	Learning Event Analysis, Significant Event Analysis
QIA	Quality Improvement Activity
PDP	Personal Development Plan
Leadership	Leadership and Management
Prescribing	Prescribing Assessment
RF	Reflection on Feedback
PPM	Placement Planning Meeting
QIP	Quality Improvement Project

"The Portfolio & Appraisal Hub turns my scribbled notes into structured, portfolio-mapped reflections. Writing up for my ARCP went from a dreaded weekend to a quick review."

HN, GP trainee

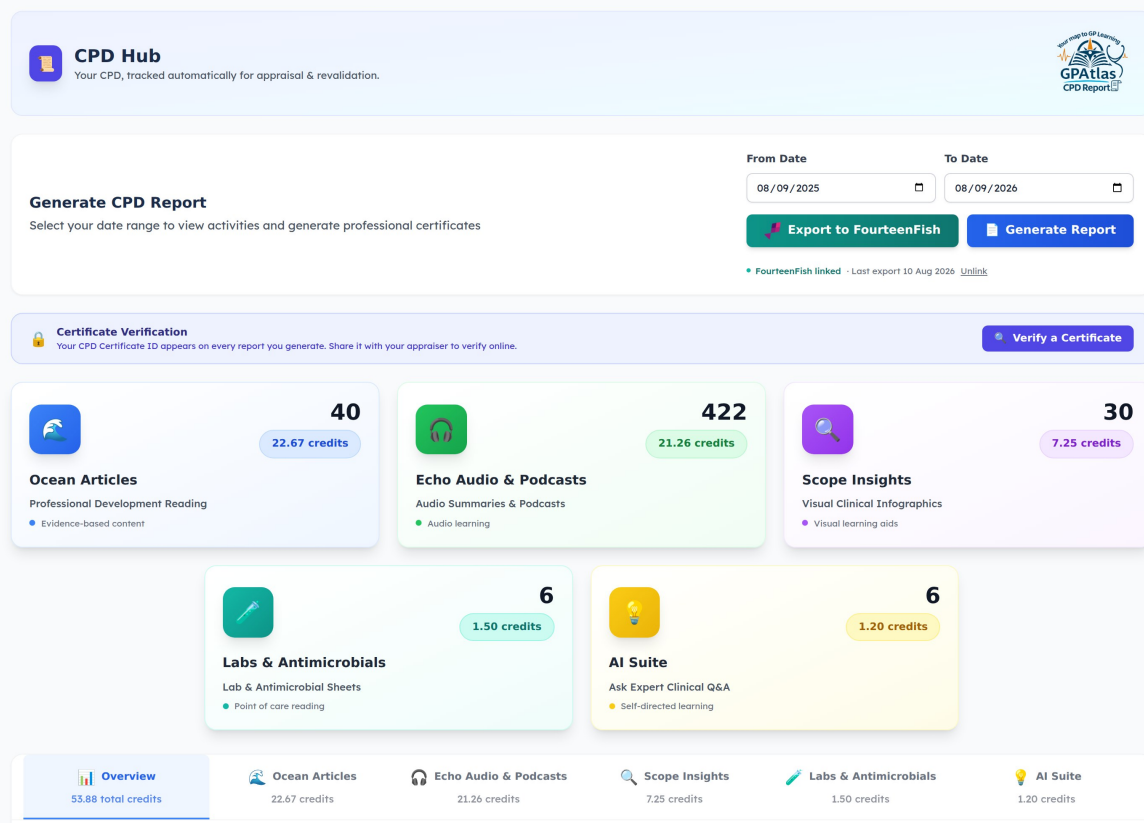
INSTEAD OF

losing a weekend before ARCP or appraisal

By appraisal week, the log is already written.

Everything you read, hear and ask on GPAtlas is logged as you go, with the credits counted for you.

gpatlas.co.uk/cpd



A year on the Hub: the credits counted by category, with the report and the FourteenFish export a tap away

The tracking starts the day you open a free account. The PDF certificates and the FourteenFish export come with a paid plan.

WHAT IT DOES WHILE YOU WORK

- **It logs itself.** Articles, audio summaries, podcasts, infographics, reference sheets and Ask Expert answers, each recorded with the time spent and the credits earned. There is nothing to type up afterwards.
- **A certificate, and the proof behind it.** Generate a report for any date range you choose. Every certificate carries its own ID, so an appraiser or an employer can confirm it at gpatlas.co.uk/cpd/verify.
- **Straight into FourteenFish.** Export your CPD across, rather than copying it over by hand.
- **Your reflections, and your own targets.** Add a reflection to any activity, the part appraisal actually asks for, and set learning goals across topics and formats to track against.

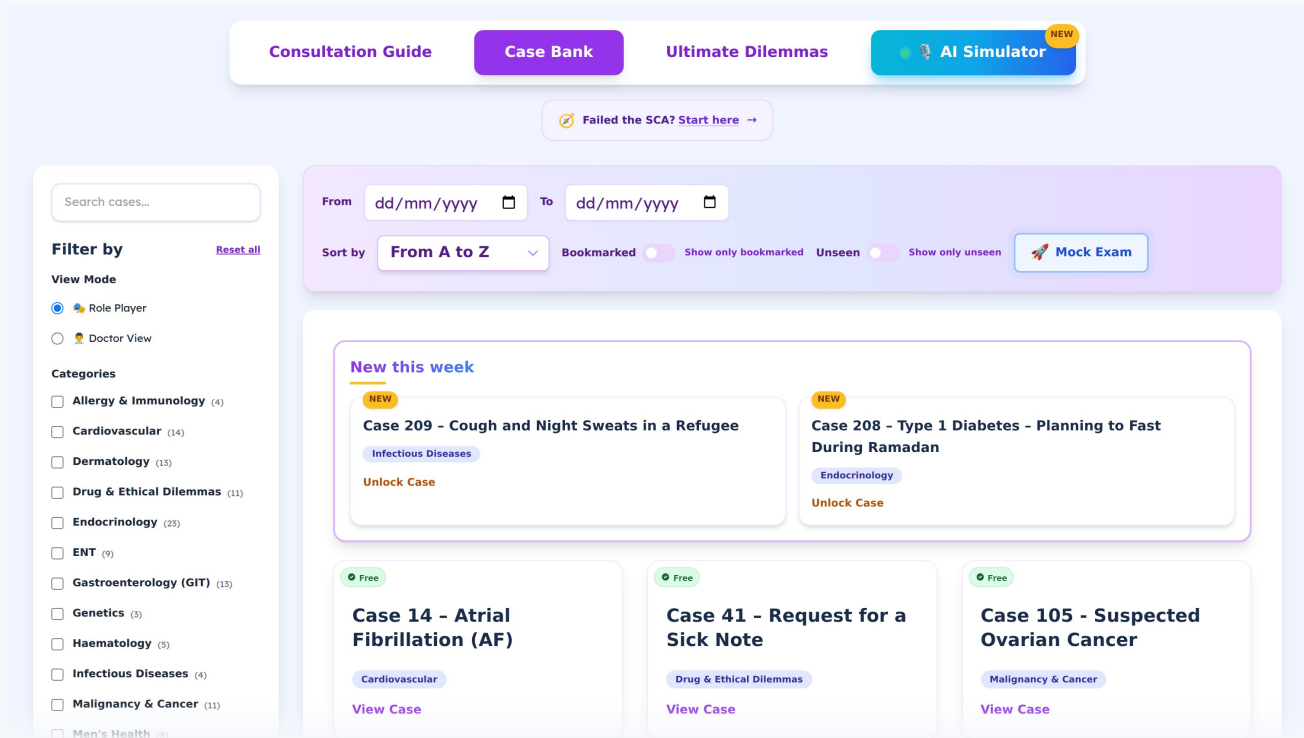
INSTEAD OF

rebuilding your CPD log the week before appraisal

Hear how a good consultation actually sounds.

200+ cases with audio walkthroughs, 300+ management dilemmas, the guide and the marking sheet, in one place.

gpatlas.co.uk/sca



The case bank, with the newest cases pinned at the top and the AI Simulator one tap away

- **The consultation guide and the marking sheet.** Both free. The guide steers every case to safety. The marking sheet covers all three domains: data gathering, communication and clinical management.
- **The case bank.** 200+ cases from practising UK GPs, each with an audio walkthrough of the whole consultation, which is the page overleaf.
- **Ultimate Dilemmas.** 300+ situations with the management in brief: the few facts that decide it, and the words to say to the patient.
- **Failed the SCA?** A calm page for resitters, a free spoken consultation with an AI patient, and a free month of your chosen plan, then 30% off for 12 months, with proof of two or more attempts.

"Finally, a platform that really knows what is needed for The SCA. It covers everything I needed; I have never seen such a comprehensive platform."

IM, GPST3

INSTEAD OF

paying again for a weekend SCA course

Exactly what to ask, and exactly what to say.

An audio walkthrough on every case, with the words running beside it.

gpatlas.co.uk/sca

Case 209 – Cough and Night Sweats in a Refugee

Edited: 6 Sept 2026

Echo Consults

Section 7 of 7

Listen to the expert audio walkthrough on exactly what to ask and what to say for this case.

10

▶

30

4:48

9:32

☒ Follow along

kitchen, and a housemate's young children visit at weekends. Write that down, it is coming back in management.

04:41

BEN

Then ask gently, you said your housemate had to push you to call us, what was it that nearly stopped you? And the patient trusts you with the real story. Honestly, doctor, I am afraid. If the hospital finds TB, will they tell the Home Office? My claim is everything, if I lose it I have nothing. And I have no money for hospital bills. Maybe it is better if nobody knows.

05:11

SARAH

Acknowledge it with real warmth, and recap if time allows. Let me make sure I have understood: six weeks of cough with drenching night sweats and weight loss, TB years ago with the tablets cut short, your biggest fear is that using the NHS could harm your asylum claim or cost money you do not have, and you were hoping this could simply wait until your papers are sorted. Have I got that right so far?

< Previous

Next >

The walkthrough on a case, with the line being spoken lit up as it is spoken

- **Sarah and Ben talk the case through out loud.** The same two voices as the podcast: what to ask, in what order, and the words to use when the consultation turns difficult.
- **Every case has one.** Hear the phrasing enough times and it arrives by **tongue memory** rather than by thinking, which is what twelve minutes rewards.
- **The words run beside the audio,** and the line being spoken lights up as it is spoken, so you never lose your place.
- **Tap any line and the audio jumps there,** so hearing something a second time takes one tap.

INSTEAD OF

a recording you cannot follow

Practise out loud at eleven at night.

A spoken consultation with an AI patient, marked on the three domains, with a spoken debrief.

gpatlas.co.uk/ace-sca-simulator

[< All cases](#) [33 credits](#)

11:52
time remaining

Case 15

 Briefing hidden, tap to show

Morning, it's Dr Ahmed, one of the GPs. What can I do for you today?

 Morning, doctor. I've been looking at my recent blood test results on the app and I'm really worried about my cholesterol.

Right, tell me a bit more about that. When did it start?

 It's been on my mind constantly since my brother-in-law died suddenly from a heart attack three weeks ago.

And what's been going through your mind about it?

 I'm just terrified that I'm next, and I don't want to leave my wife and kids behind like that.

Tap the mic once, then just talk

 Hide text

 Talk

 End & mark

A consultation under way: you speak, the patient answers, and the clock runs like the real exam

1 Pick a case

Three minutes to read your notes, like the real SCA.

2 Consult, out loud

Twelve minutes with an AI patient who answers the way a patient would.

3 Hear how it landed

Marked across the three domains, then a spoken debrief rather than a score out of ten.

Two consultations are free on a free account, no card.

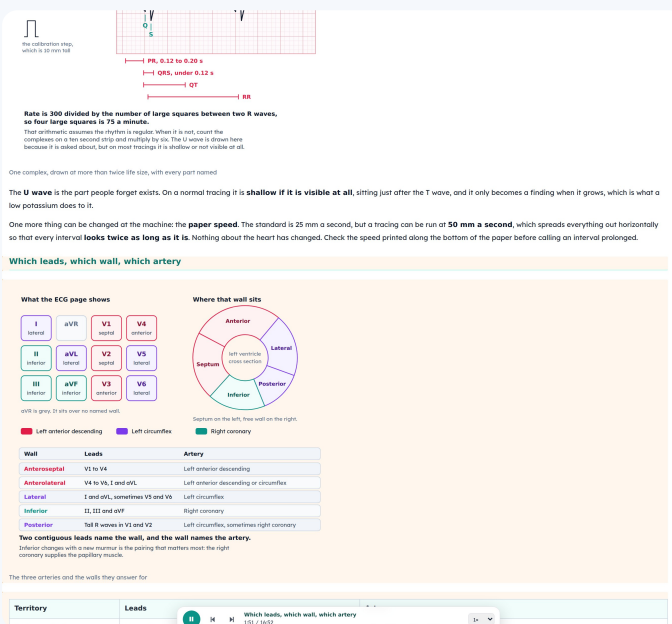
INSTEAD OF

paying for role play practice days

Revision that teaches you, instead of just scoring you.

The guideline in its shortest honest form, chapter by chapter, and every chapter read aloud.

gpatlas.co.uk/akt



the calibration step, which is 10 mm tall

Rate is 300 divided by the number of large squares between two R waves, so four large squares is 75 a minute.

That arithmetic assumes the rhythm is regular. When it is not, count the complexes on a ten second strip and multiply by six. The U wave is drawn here because it is asked about, but on most tracings it is shallow or not visible at all.

One complex, drawn at more than twice life size, with every part named

The **U wave** is the part people forget exists. On a normal tracing it is **shallow** if it is **visible at all**, sitting just after the T wave, and it only becomes a finding when it grows, which is what low potassium does to it.

One more thing can be changed at the machine: the **paper speed**. The standard is 25 mm a second, but a tracing can be run at **50 mm a second**, which spreads everything out horizontally so that every interval **looks twice as long as it is**. Nothing about the heart has changed. Check the speed printed along the bottom of the paper before calling an interval prolonged.

Which leads, which wall, which artery

What the ECG page shows

Where that wall sits

Left anterior descending Left circumflex Right coronary

Septum on the left, free wall on the right

Two contiguous leads name the wall, and the wall names the artery.

Septal changes with a low murmur is the point that matters most: the right coronary supplies the papillary muscle.

The three arteries and the walls they answer for

Territory	Leads	Which leads, which wall, which artery
Anterior	V1 to V4	Left anterior descending
Anterolateral	V4 to V6, I and aVL	Left anterior descending or circumflex
Lateral	I and aVL, sometimes V5 and V6	Left circumflex
Inferior	II, III and aVF	Right coronary
Posterior	V7 to V9	Left circumflex, sometimes right coronary

Press play and the note reads itself to you. Whatever it is reading lights up as it goes, so you never lose your place

Scalp, tinea capitis	Oral, always, plus an antifungal shampoo to cut spread	4 weeks on terbinafine, 4 to 8 weeks on griseofulvin
Trunk, pityriasis versicolor	Ketoconazole shampoo used as a lotion, or an imidazole cream. Extensive disease takes oral fluconazole 300 mg weekly or itraconazole 200 mg daily	5 days of shampoo, 2 weeks of fluconazole, 1 week of itraconazole

Two prescribing points hide in that table. **Oral ketoconazole is not used** for any of it, because of liver injury, even though the shampoo of the same drug is first line on the skin. And in tinea capitis the organism picks the drug: **terbinafine** for *Trichophyton*, which is what most UK children have, and **griseofulvin** for *Microsporum*, which is the one caught from an animal. Griseofulvin holds the licence in children and terbinafine is used off label, so start on the likelier organism and switch when the culture arrives.

Children are dosed by weight, not by age, and terbinafine is the one to be able to write out.

Weight	Terbinafine, once daily for 4 weeks
Under 20 kg	62.5 mg
20 to 40 kg	125 mg
Over 40 kg, and adults	250 mg

Tinea barboe is worth recognising on its own, because it is treated as an infected beard for weeks before anyone scrapes it. Pustules and swelling in the beard area, and the differential is the ordinary bacterial one: folliculitis from shaving, staphylococcal infection and impetigo.

The Wood lamp, and the flexures



Pityriasis versicolor: patches of altered pigment on the trunk

Pityriasis versicolor: patches of altered pigment on the trunk. Klaus D. Peter, Wiesl, Germany. CC BY 3.0 de, via Wikimedia Commons - [Bates](#)

Condition	Organism	Under a Wood lamp
Tinea capitis	<i>Microsporum</i> species only	Green
Pityriasis versicolor	<i>Malassezia furfur</i>	Yellow
Erythrasma	<i>Corynebacterium minutissimum</i>	Coral pink

The Wood lamp, and the flexures

The photograph you would actually see in clinic, credited underneath, with the voice reading that same section

WHAT THE NOTES GIVE YOU

- **Press play and listen.** Every chapter is read to you, and the part being read lights up as it goes. Follow it on the screen, or lock the phone and listen on the way to work.
- **The pictures are ours.** The ECG complex drawn on real paper with every wave named, the twelve leads matched to the wall they watch, the body maps. And a real photograph wherever the exam would put one in front of you.
- **One page per chapter for the night before.** When the evening has gone, read that instead. Same chapter, cut down to what you cannot afford to forget.
- **You always know where you are.** Every chapter is tied to the RCGP curriculum, and the ones you have finished stay ticked off, so nothing gets quietly skipped.

INSTEAD OF

reading a whole guideline the week before the exam

The two chapters everyone leaves until last.

Evidence and statistics, and organisation and administration, each taught as a chapter of its own and narrated like the rest.

gpatlas.co.uk/akt-statistics

worked example: finding a median

Systolic pressures: 145, 140, 142, 136, 150, 151

- Ordered: 136, 140, 142, 145, 150, 151
- Seven values, so the middle one is the fourth. **Median = 142**
- Total 1002, divided by 7. **Mean = 143.1**

Now diastolic: 81, 84, 76, 78, 82, 83. Ordered: 76, 78, 81, 82, 83, 84. Six values, so take the middle two: $(81 + 82) \div 2 = 81.5$.

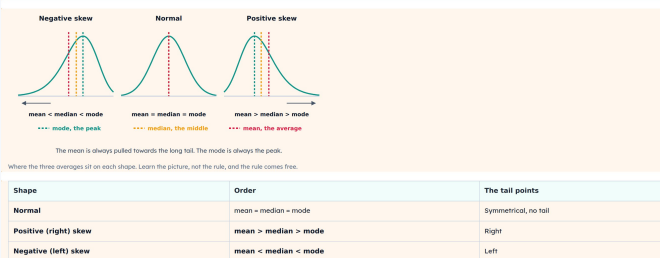
Why the choice of average matters clinically

Take waiting times in days: 2, 3, 3, 4, 4, 5, 5, 6, 90.

Measure	Value	Honest?
Mean	13.6 days	No. One long wait has dragged it away from every real patient
Median	4 days	Yes. This is what a typical patient waits

That is why **waiting times, length of stay, income and hospital costs are reported as medians**. They are all positively skewed by a small number of very large values.

Shape: skew



Two shortcuts worth having:

- The **mean is always dragged towards the long tail**. The tail is where the extreme values are, and only the mean feels them.
- You do not need a graph. **Mean above median means positive skew**. Mean below median means negative skew.
- The **mode is always the peak of the curve**, whatever the shape.
- The skew is named after where the **tail is**, not the shape.

Learn where the mean, the median and the mode land on each curve and you never have to memorise the rule again

The exception people miss

A not driver holds a Group 1 licence but is held to the Group 2 medical standard, so the licence a person carries does not always tell you which column of the tables to read.

Whose duty it is, and the one case where you notify the DVLA yourself

Vision

	Group 1	Group 2
Acuity	6/12 or better, read binocularly. A driver who has sight on one side alone is judged on that side	6/7.5 in the stronger eye, and no worse than 6/60 in the weaker
Number plate	20 metres , or 20.5 metres for older style plates	Same
Visual field	120 degrees horizontal, 50 each side, nothing significant within 20 degrees of fixation	160 degrees , 70 each side, 30 up and down, nothing within the central 30 degrees
Diplopia	May drive if controlled by a patch , with an undertaking to wear it	Patching not accepted . Inoperable diplopia means permanent refusal
Eye conditions	Which eye diseases must be declared, and how acuity and fields are measured and charted, are in the Eyes and Vision chapter	

The **6/12 is binocular**. A stem giving 4/18 in one eye and 6/9 in the other is testing exactly that.

Cardiovascular

Event	Group 1	Group 2
Elective PCI	1 week , no notification	Notify. Re-licensing after 6 weeks with LVEF 40% or more and satisfactory functional testing
Acute coronary syndrome	1 week only if PCI was successful and LVEF is at least 40% and no urgent revascularisation is planned within 4 weeks. Otherwise 4 weeks	As above, 6 weeks minimum
CABG	4 weeks	3 months
Pacemaker implant	1 week , and you must notify	6 weeks , notify
Pacemaker box change	1 week , no notification	Notify
ICD, secondary prevention	6 months from implant, and a further 6 months after any appropriate shock	Permanent bar
ICD, prophylactic	1 month	Permanent bar
ICD box change	1 week	Permanent bar
Arrhythmia causing or likely to cause inoperability	4 weeks once controlled, and notify	Cause treated, no likely recurrence for 3 months , LVEF 40% or more
Heart failure	NYHA I to III may drive if stable, no notification. NYHA IV stops	Barred at NYHA III, and LVEF below 40% bars outright
Aortic aneurysm	Notify at 6cm , annual review. Must not drive at 6.5cm or more	Notify at any size. Must not drive above 5.5cm

A recommendation for a defibrillator that the patient declines still permanently revokes a Group 2 licence, and a ventricular arrhythmia that merits one still means 6 months off Group 1 driving even if no device is fitted.

Neurology

	Group 1	Group 2
Stroke	4 weeks once controlled, and notify	3 months , LVEF 40% or more
Epilepsy	4 weeks once controlled, and notify	3 months , LVEF 40% or more
Multiple sclerosis	4 weeks once controlled, and notify	3 months , LVEF 40% or more
Alcohol	4 weeks once controlled, and notify	3 months , LVEF 40% or more
Drugs	4 weeks once controlled, and notify	3 months , LVEF 40% or more
Psychiatric	4 weeks once controlled, and notify	3 months , LVEF 40% or more
Neurology	4 weeks once controlled, and notify	3 months , LVEF 40% or more

How long each heart problem stops someone driving, and the eyesight standard for a car and for a lorry side by side

TAUGHT, RATHER THAN LEFT TO CHANCE

- Statistics you can actually follow.** Every measure is worked through with real numbers, a step at a time, and each note finishes with the mistakes that catch people out. It is about a tenth of the paper and the quickest marks you will ever pick up.
- The admin nobody ever sits you down and teaches.** Fit notes and the forms you sign, benefits, driving, confidentiality and capacity, how the contract works, and prescribing governance.
- Both are read aloud as well.** Same voice, same highlight, so the two duller chapters can be done on a walk instead of at a desk.
- And both have their own questions.** The reading and the practice sit in the same place, so you can test what you have just read while it is still fresh.

INSTEAD OF

hoping the statistics questions do not come up

Every question explains itself.

3,500+ questions, each one answered, argued and cited, with three mock exams at the real clock.

gpatlas.co.uk/akt-question-bank

DERMATOLOGY Flag Save

A 7 year old boy is brought by his mother, who noticed a lump on his cheek about two months ago. It has grown steadily since and she thinks it is bigger every week. It does not itch or hurt, he is otherwise well, and nobody in the family has had a skin cancer. The lesion is shown.

What is the **single most likely** diagnosis? Select **one** option only.



Photograph by The Armed Forces Institute of Pathology. Public domain, via Wikimedia Commons.

☒ A Juvenile xanthogranuloma

☐ B Nodular melanoma

☐ C Molluscum contagiosum

☒ D Spitz naevus

☐ E Pyogenic granuloma

Correct answer: D

ABOUT YOUR ANSWER
You chose A. Juvenile xanthogranuloma is not what the picture and story give you here. The steady weekly growth of a firm dome on the cheek of a 7 year old is the combination that names a Spitz naevus.

THE ANSWER
A firm pink or red brown dome that appears in a child and grows steadily over weeks is a **Spitz naevus** until proven otherwise. It is harmless, but under the microscope it looks so like a melanoma that it goes to dermatology rather than being watched.

WHY D IS RIGHT
This boy is **7**, the lump appeared about **two months ago** on the cheek, and it has grown every week with a smooth intact surface. Age, site and steady growth together give the classic picture. No family history of skin cancer does not change the answer, and neither does the lesion being painless: a Spitz naevus is expected to be symptomless.

WHY THE OTHER OPTIONS ARE WRONG
Pyogenic granuloma is the near miss, because it also appears quickly in a child and grows over weeks. It is wrong here because it is friable and raw and bleeds on the slightest contact, whereas this surface is smooth and unbroken.

WHAT THIS TESTS
Do not let harmless mean unrefereed. **Melanoma is very rare before puberty**, but a pink nodule is where an amelanotic one hides, so the referral is made for the histology, not because you doubt the diagnosis.

Source: 2016 CKA Melanoma Pigmented Lesions

Something wrong with this question?

Previous Next

You are shown the lesion and asked to name it, the way the exam will do it

DERMATOLOGY Flag Save

A 71 year old man is having his third episode of cellulitis in the same leg in two years. He started flucloxacillin two days ago and it is already settling. He has long standing swelling of that leg, and itchy peeling skin between his toes that he has never treated. He asks how to stop this happening again.

Which action is **most likely** to prevent another episode? Select **one** option only.



Photograph by Gabe Anderson. CC BY-SA 3.0, via Wikimedia Commons.

☐ A Arrange a duplex scan of the leg veins

☒ B Treat the fungal infection between his toes

☐ C Prescribe an antiseptic body wash for daily use

☐ D Prescribe a daily emollient for both legs

☐ E Take a skin swab and treat what grows

Correct answer: B

ABOUT YOUR ANSWER
You chose A. A duplex scan is a test, not a treatment, so by itself it prevents no further episodes, even though the chronic swelling of that leg does contribute.

THE ANSWER
Bacteria need a break in the skin to cause cellulitis. In **recurrent cellulitis of one leg**, hunt for and treat the portal of entry, and the commonest one is **untreated tinea pedis** in the toe webs.

WHY B IS RIGHT
He has itchy peeling skin between his toes that he has never treated, and it has sat there through all three episodes in the same leg. Treating it closes the door the bacteria keep using, so it is the single action most likely to prevent the next attack. **Look between the toes every time**. Tinea favours the third and fourth webs and **topical terbinafine** clears it. That the flucloxacillin is already working changes nothing here: he is asking about prevention, not about this episode.

WHY THE OTHER OPTIONS ARE WRONG
A duplex scan attracts, because chronic swelling of that leg is the other real driver of recurrence. Managing the swelling does help, but a scan by itself prevents no episodes: it is a test, not a treatment.

WHAT THIS TESTS
Answering the acute infection when the question asks about prevention. **Swabbing intact skin** grows colonisers whatever you do with the result, and antiseptic washes have no role in leg cellulitis.

Source: 2016 CKA Fungal Skin Infection Feet

Something wrong with this question?

Previous Next

Get it wrong and it tells you why the tempting answer was tempting, then shows you where the guidance says so

WHAT IS IN IT

- **Two ways to sit it.** Tutor mode explains as you go. Exam mode says nothing until the end. Either way, every question tells you where the guidance came from.
- **Three mock exams at the real clock.** 160 questions each, drawn from fixed pools so your three scores can honestly be compared. The first one is free, and the timer stretches for reasonable adjustments or neurodiversity.
- **Extended matching questions too.** The long option list the real paper uses, in the practice bank and inside the mocks.

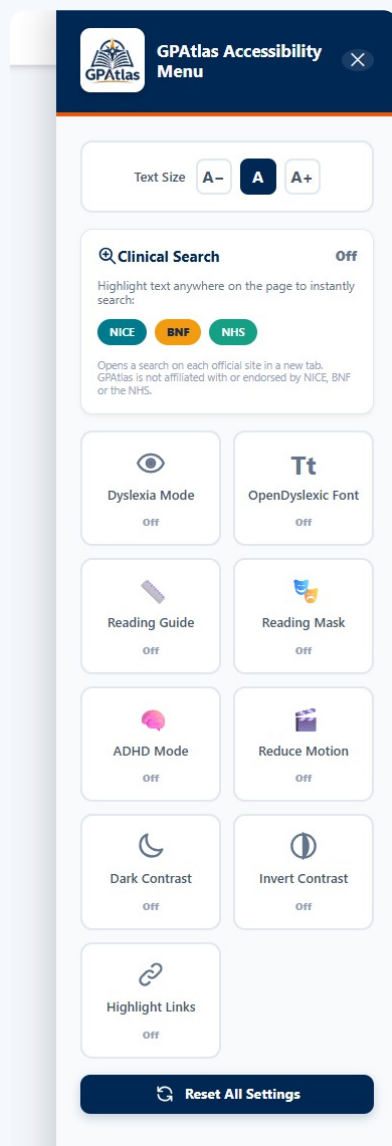
INSTEAD OF

a bank that gives you the answer and nothing else

How you read should never be the thing that holds you back.

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The Accessibility Menu, open on a real page

WHAT IS IN IT

- **Text size, Dyslexia Mode, OpenDyslexic Font.** Wider spacing, calmer lines, or the whole site in OpenDyslexic.
- **Reading Guide and Reading Mask.** A line to follow, or everything dimmed but the line you are on.
- **ADHD Mode, Reduce Motion, Dark Contrast, Invert Contrast, Highlight Links.** Remembered for your next visit.

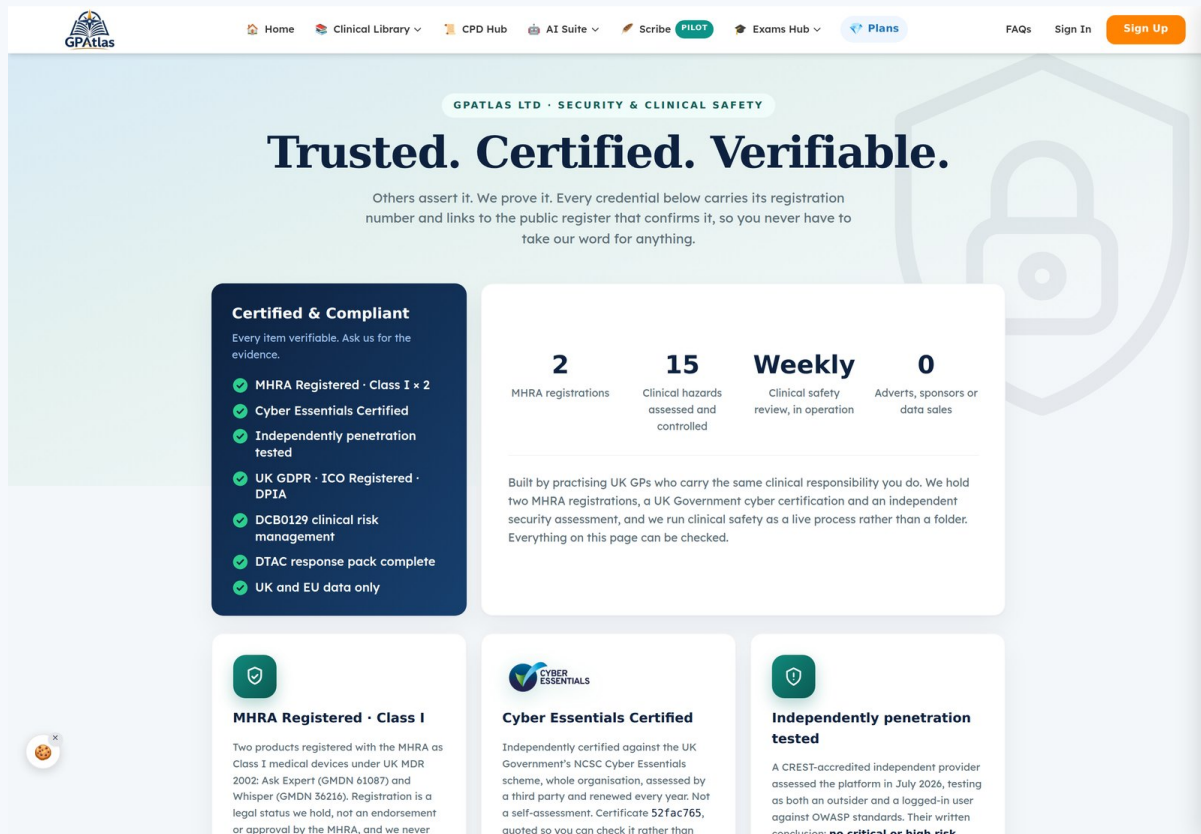
INSTEAD OF

fighting a platform that ignores how you read

Every claim carries a number you can check.

Registrations and certificates, each linked to the public register that confirms it.

gpatlas.co.uk/security



The screenshot shows the GPAtlas security page. At the top, there's a navigation bar with links to Home, Clinical Library, CPD Hub, AI Suite, Scribe, Exams Hub, and Plans. Below the navigation bar, the main heading is "Trusted. Certified. Verifiable." followed by a subheading: "Others assert it. We prove it. Every credential below carries its registration number and links to the public register that confirms it, so you never have to take our word for anything." The page is divided into several sections. On the left, a dark blue box titled "Certified & Compliant" lists several credentials: MHRA Registered - Class I x 2, Cyber Essentials Certified, Independently penetration tested, UK GDPR - ICO Registered - DPIA, DCB0129 clinical risk management, DTAC response pack complete, and UK and EU data only. To the right of this, there are four statistics: 2 MHRA registrations, 15 Clinical hazards assessed and controlled, Weekly Clinical safety review, in operation, and 0 Adverts, sponsors or data sales. Below these, a paragraph states: "Built by practising UK GPs who carry the same clinical responsibility you do. We hold two MHRA registrations, a UK Government cyber certification and an independent security assessment, and we run clinical safety as a live process rather than a folder. Everything on this page can be checked." At the bottom, there are three boxes: "MHRA Registered - Class I" with details about two products registered with the MHRA, "Cyber Essentials Certified" with details about the NCSC Cyber Essentials scheme, and "Independently penetration tested" with details about a CREST-accredited provider's assessment.

The security page, with the registers linked

WHAT IS IN IT

- Cyber Essentials certified. ICO registered, ZC021226, UK GDPR handling.
- Independently tested. Independently penetration tested by a CREST-accredited provider. The assurance letter is available to practices and NHS organisations on request.
- GPAtlas includes an MHRA Class I registered medical device. Registration is not approval or endorsement.
- Personal data is never used to train AI models. Independent: no advertising, no pharmaceutical money, no data selling.

INSTEAD OF

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