NCLEX HEMATOLOGY PRACTICE TEST (SAMPLE)

STUDY GUIDE

SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

1. Which lab pattern differentiates iron deficiency anemia from thalassemia trait?

A. Iron deficiency shows high ferritin and low TIBC; thalassemia trait shows low iron stores with low RBC count

B. Iron deficiency shows normal ferritin and low TIBC; thalassemia trait shows extremely high RBC count

C. Iron deficiency shows low ferritin and high TIBC; thalassemia trait shows normal or increased iron stores with microcytosis and relatively normal or increased RBC count

D. Iron deficiency shows high iron and low ferritin; thalassemia trait shows low iron and high TIBC

2. What are the consequences of chronic iron overload and how is it treated?

A. Iron chelation therapy only; no organ damage

B. Organ damage and chelation therapy (deferoxamine, deferasirox, deferiprone); ferritin monitoring

C. No treatment needed

D. Iron overload causes anemia; treat with iron supplements

3. Which of the following foods is a rich source of iron and often recommended for a patient with iron deficiency anemia?

A. Liver

B. Lima beans

C. Prune juice

D. Cabbage

4. What is the most common cause of iron deficiency anemia in adults?

A. Chronic blood loss

B. Dietary iron deficiency

C. Inadequate erythropoietin production

D. Genetic iron metabolism disorder

5. Pernicious anemia is caused by a deficiency of which nutrient due to loss of intrinsic factor?

A. Vitamin B12

B. Folic acid

C. Iron

D. Vitamin C

6. In disseminated intravascular coagulation (DIC), which laboratory finding indicates depletion of clotting factors?

A. Platelets 100,000/mm3

B. Fibrinogen levels 57 mg/dL

C. Fibrin degradation products 4.3 mcg/mL

D. D dimer 0.03 mcg/mL

7. Deficiency of iron in the diet leads to which hematologic reduction in iron deficiency anemia?

A. Plasma

B. WBCs

C. Hemoglobin

D. Antibodies

8. Which finding is characteristic of thrombotic microangiopathy such as TTP?

A. Microangiopathic hemolytic anemia with schistocytes on smear

B. Peripheral neuropathy without anemia

C. Hypercoagulability with D-dimer

D. Elevated platelets

9. Which statement correctly identifies an indication for erythropoiesis-stimulating agents (ESAs)?

A. Indicated for iron overload

B. Indicated for active infection

C. Indicated for CKD-related anemia or chemo-induced anemia

D. Indicated for anemia due to B12 deficiency

10. A complication associated with polycythemia due to hyperviscosity is which of the following?

A. Thrombosis

B. Cardiomyopathy

C. Pulmonary edema

D. Disseminated intravascular coagulation (DIC)

Answers

1. C
2. B
3. A
4. A
5. A
6. B
7. C
8. A
9. C
10. A

Explanations

1. Which lab pattern differentiates iron deficiency anemia from thalassemia trait?

A. Iron deficiency shows high ferritin and low TIBC; thalassemia trait shows low iron stores with low RBC count

B. Iron deficiency shows normal ferritin and low TIBC; thalassemia trait shows extremely high RBC count

C. Iron deficiency shows low ferritin and high TIBC; thalassemia trait shows normal or increased iron stores with microcytosis and relatively normal or increased RBC count

D. Iron deficiency shows high iron and low ferritin; thalassemia trait shows low iron and high TIBC

Assessing iron status markers helps distinguish iron deficiency anemia from thalassemia trait. Ferritin reflects stored iron, so in iron deficiency ferritin is low. The body responds by increasing transferrin capacity to bind iron, leading to a high TIBC. Serum iron is low and transferrin saturation is reduced, which fits iron deficiency. In thalassemia trait there isn't true iron depletion, so iron stores are normal or even increased, meaning ferritin is normal or high. Microcytosis is common, but RBC production is not impaired in the same way, so the RBC count is typically normal or increased rather than decreased. Thus, the pattern described as low ferritin with high TIBC points to iron deficiency, while normal or increased iron stores with microcytosis and a relatively normal or increased RBC count points to thalassemia trait.

2. What are the consequences of chronic iron overload and how is it treated?

A. Iron chelation therapy only; no organ damage

B. Organ damage and chelation therapy (deferoxamine, deferasirox, deferiprone); ferritin monitoring

C. No treatment needed

D. Iron overload causes anemia; treat with iron supplements

Chronic iron overload causes iron to deposit in organs, damaging tissues and leading to serious problems such as liver cirrhosis, cardiomyopathy or heart failure, diabetes from pancreatic involvement, and other endocrine issues. Treating this condition focuses on removing the excess iron and tracking how much iron remains in the body. Iron chelation therapy uses medications like deferoxamine, deferasirox, and deferiprone to bind excess iron and help eliminate it from the body. Ferritin levels are commonly monitored to gauge iron burden and response to therapy, guiding adjustments in treatment. In transfusional iron overload, chelation is essential to prevent ongoing organ damage; in other contexts like hereditary hemochromatosis, phlebotomy may be used to reduce iron stores, but chelation remains a cornerstone for many overload scenarios. The goal is to prevent or minimize irreversible organ damage by both removing iron and closely monitoring iron stores.

3. Which of the following foods is a rich source of iron and often recommended for a patient with iron deficiency anemia?

A. Liver

B. Lima beans

C. Prune juice

D. Cabbage

Iron deficiency anemia improves when you get iron in a form the body can absorb easily. Liver provides heme iron, the form that is absorbed most efficiently by the gut, so it's a rich and practical dietary source for boosting iron stores. Plant foods like lima beans do contain iron, but it's non-heme iron with lower bioavailability and more potential to be inhibited by other dietary components. Prune juice and cabbage have only small amounts of iron, making them unreliable for treating iron deficiency. So, liver stands out as a strong dietary source of iron. Pairing iron-rich foods with vitamin C can boost absorption, and moderation is wise with liver due to its high vitamin A content.

4. What is the most common cause of iron deficiency anemia in adults?

A. Chronic blood loss

B. Dietary iron deficiency

C. Inadequate erythropoietin production

D. Genetic iron metabolism disorder

Chronic blood loss is the most common cause of iron deficiency anemia in adults because iron is lost with the blood faster than it can be replenished through diet and absorption. Over time, repeated losses—often from the gastrointestinal tract (ulcers, gastritis, polyps, hemorrhoids, or even colon cancer)—deplete iron stores. As iron stores (ferritin) drop, serum iron falls and transferrin saturation decreases, while total iron-binding capacity rises. With insufficient iron, hemoglobin synthesis suffers, producing microcytic, hypochromic red blood cells. Dietary iron deficiency is much less common in adults in developed settings, since iron intake often meets needs unless there is very poor nutrition or absorption issues. Inadequate erythropoietin production causes a different pattern of anemia (often normocytic) seen with kidney disease or other conditions that blunt red cell production, not primarily iron deficiency. Genetic iron metabolism disorders typically cause iron overload rather than deficiency.

5. Pernicious anemia is caused by a deficiency of which nutrient due to loss of intrinsic factor?

A. Vitamin B12

B. Folic acid

C. Iron

D. Vitamin C

Pernicious anemia happens when intrinsic factor, the protein produced by stomach lining that is essential for absorbing vitamin B12 in the small intestine, is lost or blocked. Without intrinsic factor, vitamin B12 cannot be efficiently absorbed, leading to a deficiency that causes the characteristic megaloblastic anemia. Vitamin B12 is the nutrient whose lack creates this condition, whereas folic acid deficiency also causes megaloblastic anemia but is not caused by the loss of intrinsic factor. Iron deficiency leads to a different, typically microcytic anemia, and vitamin C deficiency causes scurvy rather than a primary vitamin deficiency related to intrinsic factor. So the nutrient involved here is vitamin B12.

6. In disseminated intravascular coagulation (DIC), which laboratory finding indicates depletion of clotting factors?

A. Platelets 100,000/mm3

B. Fibrinogen levels 57 mg/dL

C. Fibrin degradation products 4.3 mcg/mL

D. D dimer 0.03 mcg/mL

In DIC, coagulation is activated throughout the circulation, consuming clotting factors and platelets in the process. When fibrinogen, a key clotting factor, is consumed faster than it's produced, its level falls. A fibrinogen level as low as 57 mg/dL shows that clotting factors are depleted, which greatly increases bleeding risk because there isn't enough fibrinogen available to form stable clots. Normal fibrinogen is roughly 200–400 mg/dL, so this profound drop points to depletion of clotting factors. Other changes in DIC reflect different aspects: platelets can be low from consumption, while fibrin degradation products and D-dimer rise from increased breakdown of clots. So the profoundly low fibrinogen level is the clearest sign of depletion of clotting factors in DIC.

7. Deficiency of iron in the diet leads to which hematologic reduction in iron deficiency anemia?

A. Plasma

B. WBCs

C. Hemoglobin

D. Antibodies

Iron is needed to form heme, the part of hemoglobin that carries oxygen. When dietary iron is lacking, the body can't synthesize as much heme, so hemoglobin production drops. This leads to a lower hemoglobin level in the blood—the defining feature of iron deficiency anemia. The red blood cells also become smaller and paler (microcytic, hypochromic), but the key hematologic change is the decrease in hemoglobin. Plasma volume, white blood cell counts, and antibodies aren't inherently reduced by iron deficiency in the same way.

8. Which finding is characteristic of thrombotic microangiopathy such as TTP?

A. Microangiopathic hemolytic anemia with schistocytes on smear

B. Peripheral neuropathy without anemia

C. Hypercoagulability with D-dimer

D. Elevated platelets

Thrombotic microangiopathy causes tiny blood vessel thrombi that shear passing red blood cells, leading to microangiopathic hemolytic anemia. The hallmark is schistocytes on the peripheral smear, reflecting fragmented RBCs from this intravascular destruction. This MAHA goes hand in hand with consumption of platelets, so you'd expect low platelets rather than elevated ones. Lab clues include elevated LDH and low haptoglobin from hemolysis. While neurologic symptoms can occur in TTP, the defining finding here is the presence of schistocytes indicating MAHA. Options suggesting peripheral neuropathy without anemia, a hypercoagulable state with D-dimer, or elevated platelets do not capture this intravascular hemolysis and platelet consumption pattern.

9. Which statement correctly identifies an indication for erythropoiesis-stimulating agents (ESAs)?

A. Indicated for iron overload

B. Indicated for active infection

C. Indicated for CKD-related anemia or chemo-induced anemia

D. Indicated for anemia due to B12 deficiency

Erythropoiesis-stimulating agents are used to treat anemia that results from insufficient erythropoietin activity or bone marrow suppression, such as in chronic kidney disease or during chemotherapy. They stimulate the bone marrow to produce more red blood cells, which helps raise hemoglobin and reduce the need for transfusions in these specific scenarios. This is why the statement indicating CKD-related anemia or chemo-induced anemia is the correct indication. They are not used for iron overload—giving an ESA won't remove excess iron and can't address the underlying problem. They're also not given during active infection, since treating the infection takes precedence and ESA use isn't indicated in that context. Anemia caused by vitamin B12 deficiency isn't treated with ESAs either; the deficiency must be corrected with B12, after which normal RBC production can resume.

10. A complication associated with polycythemia due to hyperviscosity is which of the following?

A. Thrombosis

B. Cardiomyopathy

C. Pulmonary edema

D. Disseminated intravascular coagulation (DIC)

When hematocrit is high, blood becomes more viscous, which slows flow, especially in the microcirculation. This sluggish flow promotes stasis and activates coagulation pathways, making clot formation more likely in both arteries and veins. That combination—hyperviscosity leading to impaired perfusion and increased thrombotic risk—is the hallmark complication of polycythemia related to the thickened blood, so thrombosis is the best answer. While polycythemia can strain the heart and, in some cases, contribute to edema, and while DIC is a separate coagulopathy, they are not the classic hyperviscosity-related complication.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

https://nclexhematology.examzify.com

We wish you the very best on your exam journey. You've got this!