

Kevin's Review - 35 NCLEX Practice Questions

1. During chemotherapy, an oncology client has a nursing diagnosis of impaired oral mucous membrane related to decreased nutrition and immunosuppression secondary to the cytotoxic effects of chemotherapy. Which nursing intervention is most likely to decrease the pain of stomatitis?

- A. Monitoring the client's platelet and leukocyte counts
- B. Checking regularly for signs and symptoms of stomatitis
- C. Recommending that the client discontinue chemotherapy
- D. Providing a solution of hydrogen peroxide and water for use as a mouth rinse

Correct Answer: D. Providing a solution of hydrogen peroxide and water for use as a mouth rinse

- **Option D:** To decrease the pain of stomatitis, the nurse should provide a solution of hydrogen peroxide and water for the client to use as a mouth rinse. (Commercially prepared mouthwashes contain alcohol and may cause dryness and irritation of the oral mucosa.) The nurse also may administer viscous lidocaine or systemic analgesics as prescribed.
- **Option A:** Monitoring platelet and leukocyte counts may help prevent bleeding and infection but wouldn't decrease pain in this highly susceptible client.
- **Option B:** Checking for signs and symptoms of stomatitis also wouldn't decrease the pain.
- **Option C:** Stomatitis occurs 7 to 10 days after chemotherapy begins; thus, stopping chemotherapy wouldn't be helpful or practical. Instead, the nurse should stay alert for this potential problem to ensure prompt treatment.

2. Mrs. Chua, a 78-year-old client, is admitted with the diagnosis of mild chronic heart failure. The nurse expects to hear when listening to client's lungs indicative of chronic heart failure would be:

- A. Stridor
- B. Crackles
- C. Wheezes
- D. Friction rubs

Correct Answer: B. Crackles

Left-sided heart failure causes fluid accumulation in the capillary network of the lung. Fluid eventually enters alveolar spaces and causes crackling sounds at the end of inspiration. Pulmonary edema may cause crackling sounds in the lungs. People with congestive heart failure (CHF) often have pulmonary edema. CHF occurs when the heart cannot pump blood effectively. This results in a backup of blood, which increases blood pressure and causes fluid to collect in the air sacs in the lungs.

- **Option A:** Stridor may result from lesions involving the central nervous system (CNS), the cardiovascular system, the gastrointestinal (GI) tract, or the respiratory tract. When air passes through a narrowed flexible airway in a child, the lateral pressure that holds the airway open can drop precipitously (the Bernoulli principle) and cause the tube to close. This process obstructs airflow and produces stridor.

- **Option C:** The most common causes of wheezing are asthma and chronic obstructive pulmonary disease (COPD), which both cause narrowing and spasms (bronchospasms) in the small airways of the lungs. However, any inflammation in the throat or larger airways can cause wheezing. Common causes include infection, an allergic reaction or a physical obstruction, such as a tumor or a foreign object that's been inhaled.
- **Option D:** A pericardial friction rub is pathognomonic for acute pericarditis; the rub has a scratching, grating sound similar to leather rubbing against leather. Serial examinations may be necessary for detection, as a friction rub may be transient from one hour to the next and is present in approximately 50% of cases.

3. Which of the following tests is most effective in diagnosing hemophilia?

- A. Bleeding time
- B. Complete blood count (CBC)
- C. Partial thromboplastin time (PTT)
- D. Platelet count

Correct Answer: C. Partial thromboplastin time (PTT)

PTT is abnormal in hemophilia. Therefore, this test will be the most helpful in diagnosing the disorder. In both hemophilia A and B, PTT will be prolonged (intrinsic pathway disruption), whereas PT and BT will be normal. The PTT could be as prolonged as 2 to 3 times the high normal range. Once PTT is found to be prolonged, it should be followed by a mixing study.

- **Option A:** Bleeding time is normal in hemophilia. Kaneshiro in 1969 confirmed that the mean bleeding time was normal in hemophilia. However, 2 of 11 patients with severe hemophilia A had prolonged baseline bleeding times of 12 and 15 min, respectively.
- **Option B:** The CBC is not affected in hemophilia. After the prenatal period, the initial laboratory work includes but is not limited to complete blood count, prothrombin time (PT), partial thromboplastin time (PTT), and bleeding time (BT).
- **Option D:** The severity of the disease correlates with remaining factor levels, although individual differences in bleeding tendency are seen despite similar factor levels. While thrombin generation is severely impaired in persons with hemophilia, primary hemostasis, i.e. platelet function has been generally considered to be normal.

4. When administering dopamine (Intropin), it is most important for the nurse to know that:

- A. The drug's action varies according to the dose.
- B. The drug may be used instead of fluid replacement.
- C. The drug cannot be directly mixed in solutions containing bicarbonate or aminophylline.
- D. The lowest dose to produce the desired effect should be used.

Correct Answer: C. The drug cannot be directly mixed in solutions containing bicarbonate or aminophylline.

The nurse is responsible for knowing compatible solutions before administering dopamine (Intropin). In patients with conditions of the heart or circulatory system, the intravenous administration of dopamine

is contraindicated. These conditions may include ventricular arrhythmias and tachycardia, blood vessel blockage, low blood-oxygen content, decreased blood volume, acidosis, and adrenal gland dysfunctions resulting in high blood pressure such as pheochromocytoma.

- **Option A:** It is important to know that drug action varies by dose, but the physician is responsible for determining the dose. For stimulation of the sympathetic nervous system, the indication is for a continuous intravenous drip administration. Dopamine half-life in the systemic circulation is between 1 to 5 minutes; thus, slower forms of administration, such as oral administration, are typically ineffective.
- **Option B:** Dopamine should not be used instead of fluid replacement. Indications for DA include maintenance of blood pressure for chronic congestive heart failure, trauma, renal failure, and even open-heart surgery and shock from myocardial infarction or septicemia. DA administration in low doses may also be beneficial to manage hypotension, low cardiac output, and inadequate organ perfusion (often indicated by low urine production).
- **Option D:** Although it is true, it is not the nurse's primary concern. It is a collaborative action in which the physician is involved in determining the rate. Low infusion rates (0.5 to 2 micrograms/kg per minute) act on the visceral vasculature to produce vasodilation, including the kidneys, resulting in increased urinary flow.

5. Which of the following symptoms indicate acute rejection of a transplanted kidney?

- A. Edema, Nausea
- B. Fever, Anorexia
- C. Weight gain, pain at graft site
- D. Increased WBC count, pain with voiding

Correct Answer: C. Weight gain, pain at graft site

Pain at the graft site and weight gain indicates the transplanted kidney isn't functioning and possibly is being rejected. In general, when transplanting tissue or cells from a genetically different donor to the graft recipient, the alloantigen of the donor induces an immune response in the recipient against the graft. This response can destroy the graft if not controlled. The whole process is called allograft rejection.

- **Option A:** Transplant clients usually have edema, anorexia, fever, and nausea before transplantation, so those symptoms may not indicate rejection. Allograft rejection is inflammation with specific pathologic changes in the allograft, due to the recipient's immune system recognizing the non-self antigen in the allograft, with or without dysfunction of the allograft.
- **Option B:** Renal transplant rejection, as stated earlier, is an immunological response that leads to inflammation with specific pathological changes in the allograft, due to the recipient's immune system recognizing the non-self (foreign) antigen in the allograft.
- **Option D:** Hyperacute rejection is related to preexisting circulating antibodies in the recipient's blood against the donor antigen (usually ABO blood group or HLA antigen), which is present at the time of transplantation. These antibodies attack and destroy the transplanted organ as soon as or within a few hours after allograft is revascularized.

6. The nurse in charge is caring for a postpartum client who had a vaginal delivery with a midline episiotomy. Which nursing diagnosis takes priority for

this client?

- A. Risk for deficient fluid volume related to hemorrhage.
- B. Risk for infection related to the type of delivery.
- C. Pain related to the type of incision.
- D. Urinary retention related to periurethral edema.

Correct Answer: A. Risk for deficient fluid volume related to hemorrhage

Hemorrhage jeopardizes the client's oxygen supply — the first priority among human physiological needs. Therefore, the nursing diagnosis of Risk for deficient fluid volume related to hemorrhage takes priority over-diagnoses of Risk for Infection, Pain, and Urinary retention.

- **Option B:** Episiotomy infections are classically reported as being rare at a rate of 0.1% and increasing up to 2% if a third or fourth-degree tear occurs.
- **Option C:** Episiotomy pain may be relieved by an ice pack, warm or cold shallow baths or sitz baths, or medicated creams or local numbing sprays.
- **Option D:** Postpartum urinary retention (PPUR) is an upsetting condition that has no standard literature definition. It has been variably defined as the abrupt onset of aching or inability to completely micturate, requiring urinary catheterization, over 12 hours after giving birth or not to void spontaneously within 6 hours of vaginal delivery.

7. The antagonist for magnesium sulfate should be readily available to any client receiving IV magnesium. Which of the following drugs is the antidote for magnesium toxicity?

- A. Calcium gluconate
- B. Hydralazine (Apresoline)
- C. Narcan
- D. RhoGAM

Correct Answer: A. Calcium gluconate.

Calcium gluconate is the antidote for magnesium toxicity. Ten ml of 10% calcium gluconate is given IV push over 3-5 minutes. Hydralazine is given for sustained elevated blood pressures in preeclamptic clients.

- **Option B:** Hydralazine is used to treat high blood pressure. Hydralazine is in a class of medications called vasodilators. It works by relaxing the blood vessels so that blood can flow more easily through the body.
- **Option C:** Narcan (naloxone) is an opioid antagonist used for the complete or partial reversal of opioid overdose, including respiratory depression. Narcan is also used for diagnosis of suspected or known acute opioid overdose and also for blood pressure support in septic shock. Narcan is available in generic form.
- **Option D:** RhoGAM is a prescription medicine that is used to prevent Rh immunization, a condition in which an individual with Rh-negative blood develops antibodies after exposure to Rh-positive blood.

8. Stimulation of the sympathetic nervous system produces which of the following responses?

- A. Bradycardia
- B. Tachycardia
- C. Hypotension
- D. Decreased myocardial contractility

Correct Answer: B. Tachycardia

Stimulation of the sympathetic nervous system causes tachycardia and increased contractility. The other symptoms listed are related to the parasympathetic nervous system, which is responsible for slowing the heart rate. Studies have mainly focused on the role of the sympathetic nervous system, specifically evaluating the effect of increased sympathetic activity. It has been well documented that heart rate variability is diminished, and heart rate increases, before ventricular tachycardia in humans, which is likely reflective of increased sympathetic tone.

- **Option A:** Via the vagus nerve, the parasympathetic nervous system stimulates neurons that release the neurotransmitter acetylcholine (ACh) at synapses with cardiac muscle cells. Acetylcholine then binds to M2 muscarinic receptors, causing the decrease in heart rate that is referred to as reflex bradycardia.
- **Option C:** A key modulator of blood viscosity is the renin-angiotensin system (RAS) or the renin-angiotensin-aldosterone system (RAAS), a hormone system that regulates blood pressure and water balance. When blood volume is low, juxtaglomerular cells in the kidneys secrete renin directly into circulation.
- **Option D:** The activation of M2 receptors reduces the contractility of atrial cardiomyocytes, thus reducing, in part, the overall cardiac output of the heart as a result of reduced atrial kick, smaller stroke volume, and slower heart rate. Cardiac output is determined by heart rate and stroke volume ($CO = HR \times SV$).

9. The client is having a lumbar puncture performed. The nurse would plan to place the client in which position for the procedure?

- A. Side-lying, with legs pulled up and head bent down onto the chest.
- B. Side-lying, with a pillow under the hip.
- C. Prone, in a slight Trendelenburg's position.
- D. Prone, with a pillow under the abdomen.

Correct Answer: A. Side-lying, with legs pulled up and head bent down onto the chest

The client undergoing lumbar puncture is positioned lying on the side, with the legs pulled up to the abdomen, and with the head bent down onto the chest. This position helps to open the spaces between the vertebrae. The positioning of the patient in either a lateral recumbent position or sitting position may be used. The lateral recumbent position is preferred as it will allow an accurate measurement of opening pressure, and it also reduces the risk of post-lumbar puncture headache.

- **Option B:** The patient should be instructed to assume the fetal position, which involves the flexion of the spine. It may be helpful to instruct the patient to flex their back "like a cat." By doing so, the space between the spinous processes increases, allowing for easier needle insertion.

- **Option C:** To help keep the needle at the midline during insertion, the lumbar spine should be perpendicular to the table in the sitting position and parallel to the table if in the recumbent position. Lumbar puncture is one of the most commonly performed procedures in the emergency department. It is used in the diagnosis of potentially life-threatening diseases such as meningitis and subarachnoid hemorrhage.
- **Option D:** Lumbar puncture is a commonly performed procedure in the emergency department and can be of great clinical importance when diagnosing potentially lethal diseases such as meningitis and subarachnoid hemorrhage. With proper preparation, technique, and care, the risks of complications can be significantly reduced.

10. A female client arrives at the emergency department with chest and stomach pain and a report of black tarry stool for several months. Which of the following orders should the nurse Oliver anticipate?

- A. Cardiac monitor, oxygen, creatine kinase and lactate dehydrogenase levels
- B. Prothrombin time, partial thromboplastin time, fibrinogen and fibrin split product values
- C. Electrocardiogram, complete blood count, testing for occult blood, comprehensive serum metabolic panel
- D. Electroencephalogram, alkaline phosphatase, and aspartate aminotransferase levels, basic serum metabolic panel

Correct Answer: C. Electrocardiogram, complete blood count, testing for occult blood, comprehensive serum metabolic panel.

An electrocardiogram evaluates the complaints of chest pain, laboratory tests determine anemia, and the stool test for occult blood determines blood in the stool.

- **Option A:** Cardiac monitoring, oxygen, and creatine kinase, and lactate dehydrogenase levels are appropriate for a cardiac primary problem. A basic metabolic panel and alkaline phosphatase and aspartate aminotransferase levels assess liver function.
- **Option B:** Prothrombin time, partial thromboplastin time, fibrinogen and fibrin split products are measured to verify bleeding dyscrasias.
- **Option D:** An electroencephalogram evaluates brain electrical activity.

11. Nurse Anne is caring for a client who has been treated long term with antipsychotic medication. During the assessment, Nurse Anne checks the client for tardive dyskinesia. If tardive dyskinesia is present, Nurse Anne would most likely observe:

- A. Abnormal movements and involuntary movements of the mouth, tongue, and face.
- B. Abnormal breathing through the nostrils accompanied by a “thrill.”
- C. Severe headache, flushing, tremors, and ataxia.
- D. Severe hypertension, migraine headache.

Correct Answer: A. Abnormal movements and involuntary movements of the mouth, tongue, and face.

Tardive dyskinesia is a severe reaction associated with long-term use of antipsychotic medication. The clinical manifestations include abnormal movements (dyskinesia) and involuntary movements of the mouth, tongue (flycatcher tongue), and face. Tardive dyskinesia (TD) is a syndrome which includes a group of iatrogenic movement disorders caused due to a blockade of dopamine receptors. The movement disorders include akathisia, dystonia, buccolingual stereotypy, myoclonus, chorea, tics, and other abnormal involuntary movements which are commonly caused by the long-term use of typical antipsychotics.

- **Option B:** Tardive dyskinesia presents clinically as stereotypical involuntary movements of the tongue, neck and facial muscles, truncal musculature, and limbs. Buccolingual movements including masticatory muscles are characterized by lip-smacking, tongue protrusion, perioral movements, chewing movements, or puffing of cheeks.
- **Option C:** However, tardive dyskinesia is seen in patients who have had chronic exposure to dopamine D2 receptor blockade and rarely seen in patients who have been exposed to antipsychotics for less than three to six months. Diagnosis of acute or chronic dyskinesias may be challenging without a careful history. A thorough history of movement disorders and medication history will aid in making an accurate diagnosis of tardive dyskinesia.
- **Option D:** Tardive dyskinesia is caused due to long-term exposure to first and second-generation neuroleptics, certain antidepressants, lithium, and some antiemetic medications. Typically, the first-generation antipsychotics with increased dopamine D2 receptor affinity are affiliated with a higher risk of causing permanent abnormal involuntary movements.

12. Captopril may be administered to a client with HF because it acts as a:

- A. Vasopressor
- B. Volume expander
- C. Vasodilator
- D. Potassium-sparing diuretic

Correct Answer: C. Vasodilator

ACE inhibitors have become the vasodilators of choice in the client with mild to severe HF. Vasodilator drugs are the only class of drugs clearly shown to improve survival in overt heart failure. ACEi improves heart failure by decreasing afterload. Apart from decreasing the afterload, it also reduces cardiac myocyte hypertrophy. The Heart Outcomes Prevention Evaluation (HOPE) Study demonstrated better outcomes for those prescribed ACE inhibitors.

- **Option A:** In 2014, the Eighth Joint National Commission (JNC8) published evidence-based guidelines for the treatment of high blood pressure in adults, which recommended that ACE inhibitors are one of four drug classes recommended for initial therapy for adults with elevated blood pressure.
- **Option B:** Current recommendations are the use of ACEi or ARB as first-line therapy for hypertension in patients with a history of diabetes. Also, the use of ACEi in diabetic hypertensive patients with no history of coronary heart disease has shown to decrease the incidence of myocardial infarction and improved heart function.
- **Option D:** The other three classes of drugs are calcium channel blockers, thiazide diuretics, and angiotensin receptor blockers, which are useful as initial therapy for the general nonblack population. Only thiazide and calcium channel blockers are recommended as initial therapy for the general black population with elevated blood pressure.

13. A 43-year-old male with a history of recurrent renal calculi is admitted to the emergency department presenting with severe left flank pain radiating to the groin, nausea, and an episode of vomiting. He also reports burning and urgency during urination. His vital signs reveal a temperature of 100.8°F (38.2°C), blood pressure of 145/90 mmHg, pulse of 100 beats/min, and respiratory rate of 20 breaths/min. The client is visibly anxious and uncomfortable due to the severity of the pain. The nurse is assigned to care for the patient and must prioritize the nursing goals to ensure optimal care. Which nursing goal should be the top priority for this client?

- A. Maintain fluid and electrolyte balance
- B. Control nausea
- C. Manage pain
- D. Prevent urinary tract infection

Correct Answer: C. Manage pain

Managing pain is always a priority because it ultimately improves the quality of life. The cornerstone of ureteral colic management is analgesia, which can be achieved most expediently with parenteral narcotics or nonsteroidal anti-inflammatory drugs (NSAIDs).

- **Option A:** IV hydration in the setting of acute renal colic is controversial. Whereas some authorities believe that IV fluids hasten the passage of the stone through the urogenital system, others express concern that additional hydrostatic pressure exacerbates the pain of renal colic.
- **Option B:** Because nausea and vomiting frequently accompany acute renal colic, antiemetics often play a role in renal colic therapy. Several antiemetics have a sedating effect that is often helpful.
- **Option D:** Overuse of the more effective antibiotic agents leaves only highly resistant bacteria, but failure to adequately treat a UTI complicated by an obstructing calculus can result in potentially life-threatening urosepsis and pyonephrosis.

14. A 68-year-old woman, a former marathon runner, with a diagnosis of osteoarthritis in her right hip and knee, attends a rehabilitation clinic. Her mobility has declined over the past two years, and she is seeking guidance on using assistive devices to maintain independence. After a session on the selection and use of various mobility aids, the nurse assesses the patient's understanding. Which statement by the patient indicates a need for further teaching?

- A. "I will use a cane in the hand opposite to my affected leg."
- B. "I will adjust the height of my crutches to allow a slight bend in my elbows."
- C. "I will use a walker when I need more stability and support."
- D. "I will rely on my wheelchair for all my mobility needs to prevent joint stress."

Correct Answer: D. "I will rely on my wheelchair for all my mobility needs to prevent joint stress."

This statement indicates a misunderstanding. While wheelchairs can be used for patients with significant mobility challenges, relying solely on a wheelchair can lead to decreased strength and mobility in unaffected joints and muscles. Remaining as active as possible is crucial in osteoarthritis management to maintain joint flexibility, muscle strength, and overall physical health. Continuous wheelchair use without attempting to use other assistive devices or engage in physical activity can lead to further complications and decreased physical functionality. Proper guidance on striking a balance between mobility aids and physical activity is essential.

- **Option A:** This statement is correct. Using a cane in the hand opposite the affected leg helps distribute weight away from the painful joint and provides better support.
- **Option B:** This statement is also accurate. Proper crutch height is essential for safety and effectiveness. There should be a slight bend in the elbows when the hands are placed on the crutch handles.
- **Option C:** This statement reflects an accurate understanding. Walkers provide more stability than canes or crutches and can be beneficial for individuals with significant balance issues or those who require substantial support.

15. The nurse is teaching the mother regarding treatment for enterobiasis. Which instruction should be given regarding the medication?

- A. Treatment is not recommended for children less than 10 years of age.
- B. The entire family should be treated.
- C. Medication therapy will continue for 1 year.
- D. Intravenous antibiotic therapy will be ordered.

Correct Answer: B. The entire family should be treated.

Enterobiasis, or pinworms, is treated with Vermox (mebendazole) or Antiminth (pyrantel pamoate). The entire family should be treated to ensure that no eggs remain. Because a single treatment is usually sufficient, there is usually good compliance. The family should then be tested again in 2 weeks to ensure that no eggs remain. Enterobiasis can cause recurrent reinfection, so treating the entire household, whether symptomatic or not is recommended to prevent a recurrence.

- **Option A:** Enterobiasis usually occurs in children under 10 years of age. The male-to-female infection frequency is 2 to 1. However, a female predominance of infection is seen in those between the ages of 5 and 14 years. It most commonly affects children younger than 18 years of age. It is also commonly seen in adults who take care of children and institutionalized children.
- **Option C:** The medications used for the treatment of pinworm are either mebendazole, pyrantel pamoate, or albendazole. Any of these drugs are given in one dose initially, and then another single dose of the same drug two weeks later.
- **Option D:** Oral antibiotics are the most recommended form of treatment for enterobiasis. Young pinworms tend to be resistant to treatment and hence two doses of medication, two weeks apart are recommended. At the same time, all members of the infected child must be treated. If a large number of children are infected in a class, everyone should be treated twice at 2-week intervals. Follow-up is vital to ensure that a cure has been obtained.

16. A nurse is checking the nasogastric tube position of a client receiving a long-term therapy of Omeprazole (Prilosec) by aspirating the stomach contents

to check for the PH level. The nurse proves the correct tube placement if the PH level is?

- A. 7.75.
- B. 7.5.
- C. 6.5.
- D. 5.5.

Correct Answer: D. 5.5.

Gastric placement is indicated by a pH of less than 4 but may increase to between pH 4-6 if the patient is receiving acid-inhibiting drugs. Measuring the pH of stomach aspirate is considered more accurate than visual inspection. Stomach aspirate generally has a pH range of 0 to 4, commonly less than 4.

- **Option A:** The aspirate of respiratory contents is generally more alkaline, with a pH of 7 or more. Testing the pH of gastric aspirate to show pH ≥ 5.5 is recommended first-line test to confirm correct placement of nasogastric tubes and reduce the risk of potentially fatal aspiration.
- **Option B:** The pH readings between 4.5 and 6.0 provided the greatest overall accuracy, however, there was only moderate agreement between observers at pH readings ≥ 5.0 . Compared with studies that have taken aspirate directly from the nasogastric tube, patients undergoing scope procedures had a lower sensitivity at the pH cut-off ≥ 5.5 for identifying gastric aspirates for the whole group and in the presence and absence of antacid medications.
- **Option C:** Current healthcare guidelines recommend that the first-line test to confirm correct NGT placement prior to giving food or medications must be that the pH of an NGT aspirate is ≥ 5.5 (acidic). Nevertheless, false-positive readings might occur if the tube is misplaced in the esophagus or false-negative readings (pH > 5.5) may occur in patients who secrete less gastric acid, because of antacid medications, achlorhydria, or buffering by NGT feeds.

17. Which of the following medications decreases their action while taking thyroid hormone?

- A. Metformin
- B. Warfarin
- C. Zoloft
- D. Epinephrine

Correct Answer: A. Metformin

Metformin, an oral hypoglycemic drug when taken with a thyroid hormone decreases their action.

- **Options B, C, & D:** Warfarin (an anticoagulant), Zoloft (an antidepressant), and Epinephrine (a sympathomimetic) increases their action when taken with a thyroid hormone.

18. A teenage girl is diagnosed to have borderline personality disorder. Which manifestations support the diagnosis?

- A. Lack of self-esteem, strong dependency needs, and impulsive behavior.

- B. Social withdrawal, inadequacy, sensitivity to rejection and criticism.
- C. Suspicious, hypervigilance and coldness.
- D. Preoccupation with perfectionism, orderliness, and need for control.

Correct Answer: A. Lack of self-esteem, strong dependency needs, and impulsive behavior.

These are the characteristics of a client with borderline personality. A pattern of instability in personal relationships, intense emotions, poor self-image and impulsivity. A person with borderline personality disorder may go to great lengths to avoid being abandoned, have repeated suicide attempts, display inappropriate intense anger or have ongoing feelings of emptiness.

- **Option B:** This describes the avoidant personality. There is a pattern of extreme shyness, feelings of inadequacy and extreme sensitivity to criticism. People with avoidant personality disorder may be unwilling to get involved with people unless they are certain of being liked, be preoccupied with being criticized or rejected, or may view themselves as not being good enough or socially inept.
- **Option C:** These are the characteristics of a client with a paranoid personality. It has a pattern of being suspicious of others and seeing them as mean or spiteful. People with a paranoid personality disorder often assume people will harm or deceive them and don't confide in others or become close to them.
- **Option D:** This describes the obsessive-compulsive personality. There is a pattern of preoccupation with orderliness, perfection, and control. A person with an obsessive-compulsive personality disorder may be overly focused on details or schedules, may work excessively not allowing time for leisure or friends, or may be inflexible in their morality and values.

19. The nurse is developing a plan of care for the client scheduled for cataract surgery. The nurse documents which more appropriate nursing diagnosis in the plan of care?

- A. Self-care deficit
- B. Imbalanced nutrition
- C. Disturbed sensory perception
- D. Anxiety

Correct Answer: C. Disturbed sensory perception

The most appropriate nursing diagnosis for the client scheduled for cataract surgery is Disturbed sensory perception (visual) related to lens extraction and replacement. Although the other options identify nursing diagnoses that may be appropriate, they are not related specifically to cataract surgery. If surgery is planned, instruct the patient and/or family regarding the procedure, post-procedure care, and the need for follow-up with the physician.

- **Option A:** Instruct about complications and emergency signs and symptoms (flashing lights with loss of vision, seeing a "veil" falling over visual field, loss of vision in a specific portion of the visual field, etc.) of which to notify the physician.
- **Option B:** Ensure the room environment is safe with adequate lighting and furniture moved toward the walls. Remove all rugs, and objects that could be potentially hazardous. Provides a safe environment to reduce the potential for injury.
- **Option D:** Instruct patient and/or family regarding safe lighting. The patient should wear sunglasses to reduce glare. Advise the family to use contrasting bright colors in household

furnishings. These techniques help enhance visual discrimination and reduce the potential for injury.

20. The nurse just received the client's morning laboratory results. Which of these results is of most concern?

- A. Serum sodium level of 134 mEq/L
- B. Serum potassium level of 5.2 mEq/L
- C. Serum magnesium level of 0.8 mEq/L
- D. Serum calcium level of 10.6 mg/dL

Correct Answer: C. Serum magnesium level of 0.8 mEq/L

With a magnesium level this low, the client is at risk for ECG changes and life-threatening ventricular dysrhythmias. Normal serum magnesium levels are between 1.46 and 2.68 mg/dL. Hypomagnesemia can be attributed to chronic disease, alcohol use disorder, gastrointestinal losses, renal losses, and other conditions. Signs and symptoms of hypomagnesemia include anything from mild tremors and generalized weakness to cardiac ischemia and death.

- **Option A:** Hyponatremia is defined as a serum sodium concentration of less than 135 mEq/L but can vary to some extent depending upon the set values of varied laboratories. Patients with mild-to-moderate hyponatremia (greater than 120 mEq/L) or gradual decrease in sodium (greater than 48 hours) have minimal symptoms.
- **Option B:** Hyperkalemia is defined as a serum or plasma potassium level above the upper limits of normal, usually greater than 5.0 mEq/L to 5.5 mEq/L. While mild hyperkalemia is usually asymptomatic, high levels of potassium may cause life-threatening cardiac arrhythmias, muscle weakness or paralysis.
- **Option D:** Hypercalcemia is defined as serum calcium concentration two standard deviations above the mean values. The normal serum calcium ranges from 8.8 mg/dL-10.8 mg/dL. Primary hyperparathyroidism and malignancy accounts for 90% of the cases of hypercalcemia.

21. Methylphenidate (Ritalin) is prescribed to an 8-year-old child for the treatment of attention deficit hyperactivity disorder (ADHD). The nurse will most likely monitor which of the following during the medication therapy?

- A. Deep tendon reflex
- B. Intake and output
- C. Temperature and breath sound
- D. Height and weight

Correct Answer: D. Height and weight

Methylphenidate (Ritalin) is a central nervous system stimulant that is used to treat attention deficit hyperactivity disorder (ADHD). This medication may cause slow growth. The nurse will need to keep track of the client's height and weight to make sure that there is normal growth and development.

22. Rogelio, a 32-year-old patient, is about to be discharged from the acute care setting. Which nursing intervention is the most important to include in the plan of care?

- A. Stress-reduction techniques
- B. Home environment evaluation
- C. Skin-care measures
- D. Participation in activities of daily living

Correct Answer: B. Home environment evaluation

After discharge, the client is responsible for his own care and health maintenance management. Discharge includes assessing the home environment for determining the client's ability to maintain his health at home. All instructions for care at home, including medications, diet, therapy, and follow-up appointments, must be explained in detail to all patients and then presented in written form to take home upon discharge.

- **Option A:** The discharge plan begins at the admission time and includes the patients and their families' needs prediction, and a plan to fulfill their requirements after discharge from the hospital. A practical discharge plan helps to provide continuous care with the least amount of stress for patients.
- **Option C:** Nurses, as key members of the treatment team, play a critical role in training and taking care of the patients. One of the most basic nursing responsibilities is to provide continuous care. In this regard, the inclusion of a discharge plan for all admitted patients could be a symbol of such care.
- **Option D:** Basically, any significant change or poor performance requires physical, social, and psychological adjustment. Patients are concerned about their discharge and are preoccupied with their ability in performing their own duties and the way to handle themselves as well as joining the family. Therefore, self-care training is of utmost importance for the patients and their families.

23. When a client has a lobectomy, what fills the space where the lobe was?

- A. The remaining lobe or lobes over expand to fill the space
- B. The lung space fills up with serous fluid
- C. The space stays empty
- D. The surgeon fills the space with gel

Correct Answer: A. The remaining lobe or lobes over expand to fill the space

- **Option A:** The remaining lobe or lobes over expand slightly to fill the space previously occupied by the removed tissue. The diaphragm is carried higher on the operative side to further reduce the empty space.
- **Option C:** The space can't remain "empty" because truly empty would imply a vacuum, which would interfere with the intrathoracic pressure changes that allow breathing.
- **Option B:** Serous fluid overproduction would compress the remaining lobes, diminish their function and possibly, cause a mediastinal shift.
- **Option D:** The surgeon doesn't use a gel to fill the space.

24. Preferred nurses at the Nurseslabs Medical Center are about to perform a procedure related to a genitourinary (GU) problem to a group of pediatric patients. Which of the following groups would find it especially extra stressful?

- A. Infants
- B. Toddlers
- C. Preschoolers
- D. School-age children

Correct Answer: C. Preschoolers

In general, preschoolers have more fears because of their fantasies, contributing to fears of the simplest procedures. Castration fears are also prominent at this age and may be heightened by procedures related to GU problems. The human brain is wired to alert us to and protect us from danger. Back in the day, that could mean a panther or wolf attack—so some trepidation around furry creatures is clearly in order. While babies and toddlers are usually scared of animals, too, things get turned up a notch when an active imagination kicks in at this age, explains Dr. Chansky.

- **Option A:** A common fear during infancy is stranger anxiety, or a heightened awareness of strangers, which peaks at around 6 to 8 months. Babies have, by then, formed intimate relationships with people who care for them. Unfamiliar people will stand out, and babies will be sensitive to their personal space.
- **Option B:** At about 3 ½, children often develop a variety of insecurities and physical ways of showing them. Fear of the dark and nightmares are common and may last quite a while. Although many fears are specific to an individual child, some seem to be very typical for this age group—fear of strange animals, bathtub drains, fire, thunder and lightning, snakes, and bugs.
- **Option D:** Children are at a stage of development when they may be worried about growing up and, instead, want to remain little! Often, this is related to the fear of going off to the “big” school and first grade. It is important to allow children to feel their fears, discuss them, and even allow them to stay home for a day, if necessary.

25. Which of the following conditions most commonly causes acute glomerulonephritis?

- A. A congenital condition leading to renal dysfunction.
- B. Prior infection with group A Streptococcus within the past 10-14 days.
- C. Viral infection of the glomeruli.
- D. Nephrotic syndrome.

Correct Answer: B. Prior infection with group A Streptococcus within the past 10-14 days.

Acute glomerulonephritis is most commonly caused by the immune response to a prior upper respiratory infection with group A Streptococcus. Glomerular inflammation occurs about 10-14 days after the infection, resulting in scant, dark urine, and retention of body fluid. Periorbital edema and hypertension are common signs at diagnosis.

- **Option A:** No congenital condition predisposes to glomerulonephritis. Noninfectious causes of acute GN may be divided into primary renal diseases, systemic diseases, and miscellaneous conditions or agents.

- **Option C:** Viruses may cause acute glomerulonephritis but rarely. Cytomegalovirus (CMV), coxsackievirus, Epstein-Barr virus (EBV), hepatitis B virus (HBV), rubella, rickettsiae (as in scrub typhus), parvovirus B19, and mumps virus are accepted as viral causes only if it can be documented that a recent group A beta-hemolytic streptococcal infection did not occur. Acute GN has been documented as a rare complication of hepatitis A.
- **Option D:** Nephrotic syndrome does not cause acute glomerulonephritis. PSGN usually develops 1-3 weeks after acute infection with specific nephritogenic strains of group A beta-hemolytic streptococcus. The incidence of GN is approximately 5-10% in persons with pharyngitis and 25% in those with skin infections.

26. Which assessment finding assists the nurse in confirming inhalation injury?

- A. Brassy cough
- B. Decreased blood pressure
- C. Nausea
- D. Headache

Correct Answer: A. Brassy cough

Brassy cough and wheezing are some signs seen with inhalation injury. Damage to airway tissue causes increased mucus production, edema, denudation of epithelium, and mucosal ulceration and hemorrhage. Obstruction of airflow is often the effect caused by tissue edema narrowing the passageways and mucus/blood/fluid impeding airflow.

- **Option B:** Patients with carbon monoxide poisoning may exhibit hypotension. As carboxyhemoglobin (COHgb) levels rise, the cerebral blood vessels dilate, and both coronary blood flow and capillary density increase. Cardiac effects, especially ventricular arrhythmias occur. Ventricular arrhythmias are implicated as the cause of death most often in CO poisoning.
- **Option C:** Most commonly, patients with carbon monoxide poisoning will present with headache (more than 90%), dizziness, weakness, and nausea. Patients may be tachycardic and tachypneic.
- **Option D:** Patients may have systemic symptoms like a headache, delirium, hallucinations, and may even be comatose. Many different etiologies may cause changes in mental status including hypoxia, hypercarbia, or asphyxiant exposure (carbon monoxide, hydrogen cyanide). But headaches can also be seen with carbon monoxide poisoning.

27. When administering otic preparations, the nurse should observe the tympanic membrane for:

- A. Erythema
- B. Perforation
- C. Fluid
- D. All of the above

Correct Answer: D. All of the above

The nurse should assess all of these parameters when administering otic preparations. When a patient is seen in the clinic setting, the healthcare provider may be responsible for examining the outer structures of the ear (i.e., the earlobe and the skin around the ear) as part of the intake procedure. Be

sure to document a description of any drainage or visible wax. Before prescribing an otic preparation, the primary health care provider examines the ear's external and internal structures.

- **Option A:** Assess the patient's response to therapy. For example, a decrease in pain or inflammation should occur. Examine and palpate the outer ear and ear canal for any local redness or irritation that may indicate sensitivity to the drug.
- **Option B:** Perforated eardrums may be a contraindication to some of the otic preparations. Check with the primary health care provider before administering an otic preparation to a patient with a perforated eardrum.
- **Option C:** These drugs are contraindicated in patients with a known hypersensitivity to the drugs. The otic drugs are used with caution during pregnancy and lactation. The pregnancy category of most of these drugs is unknown when they are used as otic drugs. Drugs to remove cerumen are not used if ear drainage, discharge, pain, or irritation is present; if the eardrum is perforated; or after ear surgery.

28. Findings during an endoscopic exam include a cobblestone appearance of the colon in your patient. The findings are characteristic of which disorder?

- A. Ulcer
- B. Crohn's disease
- C. Chronic gastritis
- D. Ulcerative colitis

Correct Answer: B. Crohn's disease

Crohn's disease penetrates the mucosa of the colon through all layers and destroys the colon in patches, which creates a cobblestone appearance. As the inflammation progresses, non-caseating granulomas form involving all layers of the intestinal wall. It can develop into the classic cobblestone mucosal appearances and skip lesions along the length of the intestine sparing areas with normal mucosa.

- **Option A:** In a gastric ulcer, on histopathology, one will see an ulcer base with clear margins that penetrate the muscularis propria and into the submucosa. Inflammatory debris on the epithelial surface is often present. In the submucosa, one will see fibrosis and thickened blood vessels.
- **Option C:** H. pylori infection's first appearance of gastritis tends to be antral. The inflammation, composing mainly of mononuclear inflammatory cells and plasma cells are superficial and mostly in the upper layers of the mucosa of the corpus (body of the stomach). The chronic inflammation of gastric mucosa is associated with neutrophilic inflammation; the effects are dependent on the cytotoxicity of the H. pylori strain.
- **Option D:** Histologically, the mucosal layer of the colon in a patient with ulcerative colitis includes infiltrates of varying density and composition, depending on the stage of the disease. These infiltrates primarily consist of lymphocytes, plasma cells, and granulocytes, with the latter being more prominent during acute flares of the disease.

29. Which of the following symptoms may occur with a phenytoin level of 32 mg/dl?

- A. Ataxia and confusion

- B. Sodium depletion
- C. Tonic-clonic seizure
- D. Urinary incontinence

Correct Answer: A. Ataxia and confusion

A therapeutic phenytoin level is 10 to 20 mg/dl. A level of 32 mg/dl indicates toxicity. Symptoms of toxicity include confusion and ataxia. The neurotoxic effects are concentration dependent and can range from mild nystagmus to ataxia, slurred speech, vomiting, lethargy and eventually coma and death. Paradoxically, at very high concentrations, phenytoin can lead to seizures.

- **Option B:** Like all toxicologic exposures, the nature of the toxicity depends on fundamental pharmacologic principles: the route of exposure (oral versus parenteral), duration of exposure (acute overdose versus chronic), dosage, and the nature of metabolism (or deficiency thereof). Phenytoin displays its main signs of toxicity on the nervous and cardiovascular systems. Overdose on oral phenytoin causes mainly neurotoxicity and only very rarely causes cardiovascular toxicity.
- **Option C:** Symptoms correlate well with the unbound plasma phenytoin concentration. However, this laboratory value is seldom obtained. Seizures are very rare and usually occur at very high serum concentrations. The presence of seizures in a patient with suspected phenytoin overdose should prompt the search for other coingestants.
- **Option D:** Phenytoin does not cause urinary incontinence. Incontinence may occur during or after a seizure. Kidney disease can also lead to hypoalbuminemia as well as uremia which decreases the percentage of bound phenytoin in the plasma. Malnutrition, malignancy, and pregnancy are other causes for phenytoin toxicity in a patient on chronic therapy without any changes in dose.

30. When teaching a mother about introducing solid foods to her child, which of the following indicates the earliest age at which this should be done?

- A. 1 month
- B. 2 months
- C. 3 months
- D. 4 months

Correct Answer: D. 4 months

Solid foods are not recommended before age 4 to 6 months because of the sucking reflex and the immaturity of the gastrointestinal tract and immune system. Therefore, the earliest age at which to introduce foods is 4 months. Any time earlier would be inappropriate.

- **Option A:** 1-month old infants should stick to breast milk. Most doctors recommend waiting until at least 6 months before giving water. A 1-month-old may feed every 2-3 hours. The infant will know when to stop feeding by stopping, moving away from the breast, or falling asleep.
- **Option B:** At about 2 months of age, babies usually take 4 to 5 ounces per feeding every 3 to 4 hours.
- **Option C:** How much formula for a 3-month-old baby? Typically five ounces about six to eight times a day. How often should a 3-month-old nurse? Feedings are typically about every three or four hours at this age but each breastfed baby may be slightly different. To double-check that the baby's getting enough breast milk, check the diapers. How many wet diapers for a 3-month-old baby? About four or five very wet ones per day.

31. Which of the following foods should be avoided by clients who are prone to develop heartburn as a result of gastroesophageal reflux disease (GERD)?

- A. Lettuce
- B. Eggs
- C. Chocolate
- D. Butterscotch

Correct Answer: C. Chocolate

Ingestion of chocolate can reduce lower esophageal sphincter (LES) pressure leading to reflux and clinical symptoms of GERD. Ingesting cocoa can cause a surge of serotonin. This surge can cause the esophageal sphincter to relax and gastric contents to rise. Caffeine and theobromine in chocolate may also trigger acid reflux. All of the other foods do not affect LES pressure.

- **Option A:** Vegetables are naturally low in fat and sugar, and they help reduce stomach acid. Good options include green beans, broccoli, asparagus, cauliflower, leafy greens, potatoes, and cucumbers.
- **Option B:** Egg whites are a good option. Stay away from egg yolks, though, which are high in fat and may trigger reflux symptoms. Reflux symptoms may result from stomach acid touching the esophagus and causing irritation and pain.
- **Option D:** The foods the patient eats affect the amount of acid the stomach produces. Eating the right kinds of food is key to controlling acid reflux or GERD, a severe, chronic form of acid reflux. Sources of healthy fats include avocados, walnuts, flaxseed, olive oil, sesame oil, and sunflower oil. Reduce the intake of saturated fats and trans fats and replace them with these healthier unsaturated fats.

32. Nurse Catherine is changing a dressing and providing wound care. Which activity should she perform first?

- A. Assess the drainage in the dressing.
- B. Slowly remove the soiled dressing.
- C. Wash hands thoroughly.
- D. Put on latex gloves.

Correct Answer: C. Wash hands thoroughly.

When caring for a client, the nurse must first wash her hands. Putting on gloves, removing the dressing, and observing the drainage are all parts of performing a dressing change after hand washing is completed. When applying or changing dressings, an aseptic technique is used in order to avoid introducing infections into a wound. Even if a wound is already infected, an aseptic technique should be used as it is important that no further infection is introduced.

- **Option A:** Complete a wound assessment. This includes a visual check and comparing and evaluating the smell, amount of blood or ooze (excretions) and their color, and the size of the wound. If the site has not improved as expected, then the treating physician or senior charge nurse must be informed so they too can evaluate it and consider changing the care plan.
- **Option B:** Wash hands and put on non-sterile gloves (to protect yourself) before removing an old dressing. Dispose of this dressing in a separate dirty clinical waste bag. Start from the dirty area

and then move out to the clean area. Be very careful when doing this as the tissue or skin may be tender and there may also be sutures in place. Clean the area without causing further damage or distress to the patient.

- **Option D:** Wash hands and put on sterile gloves. If the gloves become decontaminated, remove them, re-wash hands, and put on new sterile gloves. This is best practice, but where resources are not available, safe modifications to this process can be made, for example by using non-sterile gloves to protect the nurse while removing the dressing

33. The community nurse practicing primary prevention of alcohol abuse would target which groups for educational efforts?

- A. Adolescents in their late teens and young adults in their early twenties.
- B. Elderly men who live in retirement communities.
- C. Women working in careers outside the home.
- D. Women working in the home.

Correct Answer: A. Adolescents in their late teens and young adults in their early twenties

High-risk groups for alcohol abuse include individuals between ages 18 and 25 and the unemployed. According to the 2015 National Survey on Drug Use and Health conducted by the Substance Abuse and Mental Health Administration, an estimated 20.8 million Americans age 12 and older had a substance use disorder, of which 15.7 million were alcohol use disorders. Of the people with alcohol use disorder and illicit drug disorder, 623,000 of these were adolescents ages 12 to 17 (2.5% of all adolescents).

- **Option B:** There is no evidence that elderly men in retirement communities have increased rates of alcohol abuse. Almost four million (3.8 million) individuals ages 18-25 (10.9% of young adults) and 11.3 million individuals 26 years or older (5.4%) had both an alcohol use disorder and illicit drug disorder. However, this number has been steadily declining since 2002. Almost half of the people with any substance abuse problem, including alcohol, also had a co-existing mental illness.
- **Option C:** Rates of the disorder are greater among adult men (12.4%) than among adult women (4.9%). Alcohol use disorder is a common disorder in the United States. The 12-month prevalence of alcohol use disorder is estimated to be 4.6% among 12 to 17-year-olds and 8.5% among adults aged 18 years and older in the United States.
- **Option D:** Men have 2 to 3 times increased risk than women of abusing alcohol. Among adults, the 12-month prevalence of alcohol use disorder is clearly greater among Native Americans and Alaska Natives (12.1%) than among whites (8.9%), Hispanics (7.9%), African Americans (6.9%), and Asian Americans and Pacific Islanders (4.5%).

34. Patrick who is hospitalized following a myocardial infarction asks the nurse why he is taking morphine. The nurse explains that morphine:

- A. Decrease anxiety and restlessness
- B. Prevents shock and relieves pain
- C. Dilates coronary blood vessels
- D. Helps prevent fibrillation of the heart

Correct Answer: B. Prevents shock and relieves pain

Morphine is a central nervous system depressant used to relieve the pain associated with myocardial infarction, it also decreases apprehension and prevents cardiogenic shock. FDA-approved usage of morphine sulfate includes moderate to severe pain that may be acute or chronic. Most commonly used in pain management, morphine provides major relief to patients afflicted with pain.

- **Option A:** Benzodiazepines decrease anxiety and restlessness. Indications for benzodiazepine administration include, but are not limited to, anxiety disorders, insomnia, acute status epilepticus, induction of amnesia, spastic disorders, seizure disorders, and agitation.
- **Option C:** Calcium channel blockers, such as nitroglycerin, dilate large coronary blood vessels. The dihydropyridines, in therapeutic dosing, have a little direct effect on the myocardium, and instead, are more often peripheral vasodilators, which is why they are useful for hypertension, post-intracranial hemorrhage associated vasospasm, and migraines.
- **Option D:** Antiplatelets and anticoagulants help prevent atrial fibrillation by preventing blood clot formation. Antiplatelet medications divide into oral and parenteral agents. Oral agents subdivide further based on the mechanism of action. Aspirin was the first antiplatelet medication and is a cyclooxygenase inhibitor.

35. The nurse is assessing a child diagnosed with a brain tumor. Which of the following signs and symptoms would the nurse expect the child to demonstrate? Select all that apply.

- A. Increased appetite
- B. Vomiting
- C. Polydipsia
- D. Lethargy
- E. Head tilt
- F. Increased pulse

Correct Answer: B, D & E

Head tilt, vomiting, and lethargy are classic signs assessed in a child with a brain tumor. Clinical manifestations are the result of location and size of the tumor. Tumors that develop in the brain are called primary tumors. Tumors that spread to the brain after forming in a different part of the body are called secondary tumors or metastatic tumors. This article focuses on primary tumors. There are more than 100 types of primary brain and spinal cord tumors.

- **Option A:** Increased appetite is not a sign of brain tumor. Seizures are the second most common symptom of presentation. The pathophysiology of seizures is attributed to tumor irritation to the cerebral cortex that leads to focal or generalized seizures. Other presenting symptoms of gliomas are tingling sensations, weakness, difficulty ambulation, and in rare cases, patients can present in a comatose state due to hemorrhage within the tumor which leads to an acute herniation syndrome.
- **Option B:** The most common presentations in brain gliomas are headaches, nausea, vomiting, seizures, and in more advanced cases weakness or altered mental status. Other symptoms related to mass effects include nausea, vomiting, and change in vision.
- **Option C:** Polydipsia is not found in a patient with a brain tumor. Symptoms that may be specific to the location of the tumor include changes in judgment, including loss of initiative, sluggishness, and muscle weakness or paralysis is associated with a tumor in the frontal lobe of the cerebrum; or

changes in speech, hearing, memory, or emotional state, such as aggressiveness and problems understanding or retrieving words can develop from a tumor in the frontal and temporal lobe of the cerebrum.

- **Option D:** The neurological examination of these patients can be normal or present with different degrees of focal weakness, sensory deficits, or in a severe situation altered mental status due to an acute mass effect resulting from the tumor swelling.
- **Option E:** Headaches are the most common initial presenting symptom of patients with glioma. The pathophysiology of headaches is theorized to be the result of tumor growth that places a mass effect on surrounding tissue. The mass effect, in turn, leads to pressure in the microvasculature and leads to edema. Depending on the location of the tumor in the brain, the mass effect leads to signs of a brain tumor.
- **Option F:** Meningiomas present with typical brain tumor symptoms such as headaches, vision problems, or seizures. A headache—even a severe one—on its own is seldom a symptom of meningioma or any other brain tumor.