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Pregnancy is a state of having implanted products of conception located either in the uterus or elsewhere in the body. It ends through either spontaneous or elective abortion or delivery. During this time, the mother's body goes through immense changes involving all organ systems to sustain the growing fetus. All medical providers must be aware of these alterations present in pregnancy to be able to provide the best possible care for both mother and fetus.The female body goes through immense changes during a pregnancy that involve all organ systems in the body. These changes result in physiology that differs from that of a non-pregnant female. Additionally, abnormalities in the development of pregnancy can lead to further complications for both mother and fetus. With the maternal mortality rate in the United States reaching almost 18 deaths per 100,000 live births in 2009, a drastic increase from the 7.2 deaths per 100,000 in 1987, it has become more critical for all healthcare providers to understand the typical changes that accompany pregnancy, as well as recognize changes that go beyond typical pregnancy symptoms.[1]The fertilization of an egg with a sperm starts the process of embryogenesis. The fertilized egg goes through several divisions to form a blastocyst. This blastocyst then initiates implantation with the maternal endometrium. Implantation triggers the uterine stroma to undergo decidualization to accommodate the embryo. This decidua supports embryo survival and appears to act as a barrier against immunologic responses. Additionally, upon implantation, human chorionic gonadotropin (hCG) begins to be secreted, allowing the sustenance of pregnancy. The blastocyst then begins the process of forming three distinct germ layers, including the ectoderm, mesoderm, and endoderm. At this stage, the blastocyst then becomes an embryo. The embryo goes through a process known as organogenesis, in which the majority of the major organ systems develop. After 8 weeks from implantation, or 10 weeks gestational age, the embryo is then termed a fetus until birth.[2]The duration of pregnancy, from implantation of a fertilized ovum to birth, is taken as 266 days. However, as pregnancy dating is typically from the first day of the last menstrual period, the duration of pregnancy is considered to be 280 days on average. This duration is the amount of time by which approximately half of all women will deliver their babies. Babies born from 37 0/7 weeks gestation to 38 6/7 weeks are considered early term. Those born between 39 0/7 weeks and 40 6/7 weeks are labeled full term. Babies born 41 0/7 weeks through 41 6/7 weeks are titled late-term. Any baby born at 42 0/7 weeks gestation and beyond is deemed post-term.[3]Pregnancy induces a coordinated response of multiple organ systems to support both mother and fetus. Female Reproductive System [4] To accommodate a growing fetus, the uterus must undergo extreme structural changes and cellular hypertrophy. During this time, the uterus must maintain a passive noncontractile state; this occurs through elevated levels of progesterone, which act to relax smooth muscle—growth of the placenta results in uterine tissue and vascular remodeling. Hormonal signals, primarily estrogen, are responsible for initiating the uterine growth process during early pregnancy. The uterus increases from 70 g to 1100 g, with its volume capacity increasing from 10 mL to 5 L. Between weeks 12 and 16, the lower uterine corpus unfolds, allowing the uterus to become more spherical and giving room for amniotic sac expansion with minimal stretching of the uterus. When fetal growth rate begins to accelerate at 20 weeks, the uterus rapidly elongates, and the walls thin. The longitudinal diameter grows more rapidly than the left-right and anterior-posterior diameters, with the maximum rate of elongation happening between weeks 20 and 32. By 28 weeks, the maximum fetal growth rate has occurred, and the uterine tissue growth slows while continuing to stretch rapidly and become thin. Within several weeks of delivery, the uterus then returns to its pre-pregnancy structure. Cardiovascular [5] During pregnancy, the cardiac output increases by 30 to 60%, with the majority of the increase occurring during the first trimester. The maximum output is reached between 20 and 24 weeks and is maintained until delivery. Initially, the increase in cardiac output is due to an increase in stroke volume. As the stroke volume decreases towards the end of the third trimester, an increase in heart rate acts to maintain the increased cardiac output.Systemic vascular resistance decreases, resulting in decreased arterial blood pressure. Systolic blood pressure decreases by approximately 5 to 10 mm Hg, and diastolic blood pressure decreases by 10 to 15 mm Hg. This decrease reaches its lowest point at 24 weeks, at which point it slowly returns to pre-pregnancy levels. This decrease in arterial blood pressure is due to the elevated progesterone levels present during pregnancy. Progesterone leads to smooth muscle relaxation, thus decreasing vascular resistance.Due to these physiological changes, bounding or collapsing pulses, as well as ejection systolic murmurs, are present in the majority of pregnant women. A third heart sound may be present, and ectopic beats and peripheral edema are also common. The changes in the position of the heart that occur as pregnancy progress lead to ECG changes that are considered normal findings in pregnancy. These include: atrial and ventricular ectopic beats, small Q waves and inverted T waves in lead III, ST-segment depression and T wave inversion in inferior and lateral leads, and left axis shift. Pulmonary [6] During pregnancy, the diaphragm elevates, resulting in a 5% decrease in total lung capacity (TLC). However, the tidal volume (TV) increases by 30 to 40%, thereby decreasing the expiratory reserve volume by 20%. Minute ventilation is similarly increased by 30 to 40%, owing to the fact that TV becomes increased while a constant respiratory rate is maintained.The increase in minute ventilation that occurs during pregnancy allows for an increase in alveolar (PAO2) and arterial (PaO2) PO2 levels and a decrease in PACO2 and PaCO2. PaCO2 decreases from a pre-pregnancy level of 40 mm Hg to 30 mm Hg by 20 weeks. This decrease in PaCO2 creates an increased CO2 gradient between the fetus and mother, thus enhancing oxygen delivery and carbon dioxide removal in the fetus. This gradient is created by elevated progesterone levels, which appear to act to either increase the responsiveness of the respiratory system to CO2 or to be a primary stimulant. These changes are needed to accommodate the 15% increase in metabolic rate and the 20% increase in oxygen consumption that occurs during pregnancy.Decreased PaCO2 levels, increased tidal volume, and decreased total lung capacity combine to result in dyspnea of pregnancy in approximately 60% to 70% of pregnant patients. This feeling is a subjective sensation of breathlessness with no hypoxia present. It is most common during the third trimester but can start at any time. Gastrointestinal [6] Elevated levels of estrogen, progesterone, and human chorionic gonadotropin (hCG) combine to bring about nausea and vomiting, commonly termed morning sickness. Hypoglycemia can be an additional cause of nausea. Morning sickness develops in over 70% of pregnancies and can occur at any time of day. It typically resolves by weeks 14 to 16 but persists beyond week 20 in about 10-20% of pregnant patients. If nausea and vomiting are severe enough to lead to ketosis and weight loss greater than or equal to 5% of pre-pregnancy weight, the term for this is hyperemesis gravidarum. In these patients, intravenous fluid and vitamin substitution may be necessary.Elevated progesterone levels induce smooth muscle relaxation, leading to prolonged gastric emptying time. When combined with decreased gastroesophageal sphincter tone and upwards displacement of the stomach, reflux often occurs. Progesterone-mediated smooth muscle relaxation also leads to decreased motility in the large bowel, resulting in increased water absorption and constipation. Renal [6] The renin-angiotensin-aldosterone system is activated in early pregnancy, consequently increasing sodium reabsorption. However, an increased glomerular filtration rate (GFR) acts to maintain sodium plasma levels. Additionally, elevated progesterone and prostacyclin, along with angiotensin I receptor modification in pregnancy, leads to a relative resistance to angiotensin II. This state acts to balance the vasoconstrictive effect of angiotensin and allows for vasodilation of the renal arteries mediated by relaxin stimulation of endothelium to synthesize nitric oxide.Due to renal vasodilation, both the GFR and renal plasma flow increase. The GFR increases 50% starting in early pregnancy, and this increase remains until delivery. The decrease in systemic vascular resistance results in both afferent and efferent arterioles experiencing decreased vascular resistance, thus maintaining glomerular hydrostatic pressure—the resulting increased renal blood flow results in an increase in kidney size. Progesterone acts to reduce ureteral tone, peristalsis, and contraction pressure, thereby dilating the ureters.The elevation in GFR acts to decrease blood urea nitrogen and creatinine by 25%. The elevated GFR, combined with increased glomerular capillary permeability to albumin, results in an increase of fractional excretion of protein to as much as 300 mg/day. Less effective tubular reabsorption of both glucose and urea results in increased excretion rates. Hematology [6] In pregnancy, the RBC volume increases by 20% to 30%, while the plasma volume increases by 45 to 55%. This disproportionate volume increase leads to dilutional anemia with decreased hematocrit. WBC count increases to 6 to 16 million/mL and can be as high as 20 million/mL during and shortly after labor. Platelet concentration decreases slightly due to the increased plasma volume but typically stays within normal limits. A small proportion of women (5 to 10%) will have platelet levels between 100 and 150 billion/L without any pathology present. Fibrinogen and factors VII – X levels increase, but the clotting and bleeding times remain unchanged. However, increased venous stasis and damaged vessel endothelium result in higher rates of thromboembolic events during pregnancy. The increase in the risk of thromboembolic events starts in the first trimester and continues at least 12 weeks postpartum. Endocrine [6] The increased levels of estrogen in pregnancy result in a stimulation of thyroid-binding globulin, which then increases levels of thyroxine (T4) and tri-iodothyronine (T3). Free T3 and T4 levels are slightly altered, but remain relatively constant, with a slight decrease in the second and third trimesters. TSH levels decrease somewhat in the first trimester due to the weakly stimulating effect of hCG on the thyroid but increase again by the end of the first trimester. Despite the changes, pregnancy is considered to be a euthyroid state.During pregnancy, there is an increase in hormone production by the adrenal glands. The reduced vascular resistance and blood pressure stimulate the RAA system, resulting in a three-fold increase in aldosterone by the end of the first trimester and a ten-fold increase by the end of the third trimester. There is also an increase in the production of cortisol, adrenocorticotropic hormone (ACTH), corticosteroid-binding globulin (CGB), and deoxycorticosterone, resulting in a hyper cortisol state. By the end of the third trimester, total cortisol levels are three times higher than in non-pregnant women. By the end of pregnancy, the placenta contributes to the increased cortisol state due to its production of corticotropin-releasing hormone, thus helping to trigger labor.The increased levels of estradiol in pregnancy result in an increase in prolactin, with serum prolactin levels increasing ten-fold by the end of pregnancy. This increased production induces growth in the pituitary gland caused by the proliferation of cells in the anterior lobe. Oxytocin levels, produced by the posterior pituitary, increase throughout pregnancy and peak at term. Elevated estrogen, progesterone, and inhibin act to inhibit the production of follicle-stimulating hormone (FSH) and luteinizing hormone (LH), making these levels undetectable. Musculoskeletal and Dermatologic [6] The shift in the center of gravity that occurs with pregnancy results in increased lordosis of the lower back and flexion in the neck. This shift in posture can cause lower back strain that worsens as the pregnancy progresses. Increased mobility and widening of the sacroiliac joints and pubic symphysis occur, as well as joint laxity in the lumbar spine. Carpal tunnel syndrome is a common occurrence in pregnancy due to compression of the median nerve.Increased estrogen levels result in spider angiomata and palmar erythema. Elevated melanocyte-stimulating hormones and steroid hormones lead to hyperpigmentation of the face, nipples, perineum, abdominal line, and umbilicus. Metabolism [6] The placenta produces human placental lactogen (hPL), which acts to supply nutrition to the fetus. It induces lipolysis to increase free fatty acids, which are preferentially used by the pregnant mother for fuel. It also acts as an insulin antagonist to induce a diabetogenic state. This activity prompts hyperplasia of pancreatic beta-cells to create increased insulin levels and protein synthesis. In early pregnancy, maternal insulin sensitivity increases, followed by resistance in the second and third trimesters.Total serum cholesterol and triglyceride levels increase during pregnancy due to increased synthesis in the liver and decreased activity of lipoprotein lipase. LDL cholesterol increases throughout pregnancy, with a 50% increase by term. HDL cholesterol increases during the first half of pregnancy and then falls in the third trimester while still staying above non-pregnant levels. The increase in triglycerides is essential for supplying the mother's energy while sparing glucose for the fetus. The increased LDL levels are crucial for placental steroidogenesis.There are increased caloric and nutritional requirements during pregnancy, including increased requirements for protein, iron, calcium, folate, and other vitamins and minerals. The protein requirement in pregnancy increases from 60 g/day to 70 to 75 g/day, as the amino acids are transported to the developing fetus. The calcium requirement increases to 1.5 g/day, due to the fetus's requirement of 30 g of calcium. Maternal serum levels of calcium are maintained in pregnancy, with fetal needs being met by increased intestinal absorption starting at week 12.The primary function of pregnancy is to allow for the growth and development of the fetus. All changes that occur within the mother's body are intended to allow for this growth, as well as for the development of the placenta to nourish the fetus and sustain the pregnancy.The menstrual cycle ranges from 26 to 35 days, with 28 days being the average duration. Menstrual bleeding begins on the first day of the menstrual cycle, and the heaviest flow occurs, on average, on day 2. The beginning of the menstrual cycle comprises the follicular phase, during which FSH from the pituitary gland stimulates the development of a primary ovarian follicle. This follicle induces estrogen production, allowing the uterine lining to proliferate. A spike in LH, triggered by the estrogen surge, stimulates ovulation and begins the luteal phase. The greatest probability of conception occurs in the follicular phase, one day before ovulation. However, the fertile phase spans the time between 5 days before and the day of ovulation. After ovulation, the corpus luteum secretes progesterone, maintaining the endometrial lining for a fertilized ovum. If fertilization does not occur or the fertilized ovum does not implant into the endometrial lining, then the corpus luteum degenerates, progesterone levels fall, and the endometrial lining sloughs off to begin the menstrual cycle again. [7]If a fertilized ovum successfully implants into the endometrium, the trophoblast cells proliferate into syncytiotrophoblast cells and begin to produce hCG.[7] This sustains the corpus luteum to maintain the secretion of progesterone and estrogen, allowing the pregnancy to develop. The syncytiotrophoblast, along with the cytotrophoblast and extraembryonic mesoderm, goes on to form the placenta. The primary purpose of the placenta is to sustain the pregnancy and meet the demands of the fetus. The placental membrane allows for the exchange of nutrients and gases between the fetus and the mother's body, acting as the fetal respiratory, gastrointestinal, endocrine, renal, hepatic, and immune systems.[8]Pregnancy ends with the delivery of the fetus. There are several theories as to how labor initiates. Some studies show that labor becomes triggered by the withdrawal of progesterone and mechanical stretch experienced by the uterine wall.[4] Other studies suggest that inflammatory mediators, such as prostaglandins, are vital in initiating uterine contractions.[9] Oxytocin then goes on to sustain contractions during labor and delivery.[10]Indications for testing to confirm pregnancy, either through urine or serum sample, include a female of child-bearing age with amenorrhea, dysmenorrhea, pelvic pain, abdominal pain, syncope, lightheadedness, dizziness, hypotension, tachycardia, nausea or vomiting, vaginal discharge, or urinary symptoms. Levels of hCG in a viable intrauterine pregnancy double approximately every 48 hours in early pregnancy. Levels peak around 10 to 12 weeks gestation, then decline to a steady state after 15 weeks.[11] Ultrasound confirmation of early pregnancy is utilized when an individual has a positive pregnancy test along with pelvic pain, abdominal pain, or vaginal bleeding.[12]Confirmation of a viable pregnancy occurs with an ultrasound, which shows a gestational sac on transvaginal ultrasound at five weeks or with an hCG level of 1,500 to 2,000 mIU/mL. Fetal heart motion is visible on transvaginal ultrasound at six weeks or with hCG levels starting at 5,000 to 6,000 mIU/mL.[12]As the purpose of the placenta is to support and maintain the pregnancy, any abnormality in placenta formation can result in adverse outcomes for both mother and fetus. Abnormalities can be in the form of the structure of the placenta, the location of the placenta, and the implantation of the placenta.Preeclampsia appears to involve both maternal and fetal factors, leading to abnormal development of the vasculature in the placenta; this ultimately leads to under-perfusion, resulting in hypoxia and growth restriction. Maternal endothelial dysfunction, believed to be due to antiangiogenic factors, leads to increased vascular permeability, with activation of the coagulation cascade, vasoconstriction, and microangiopathic hemolysis. These factors lead to the clinical manifestations of preeclampsia, including hypertension, proteinuria, seizure, cerebral hemorrhage, DIC, renal failure, pulmonary edema, uteroplacental insufficiency, placental abruption, premature delivery, and increased rate of cesarean section deliveries. Preeclampsia falls into two categories, preeclampsia without severe features and preeclampsia with severe features. To be diagnosed without severe features, third-trimester blood pressure greater than 140/90 mm Hg on two occasions at least 6 hours apart is needed, as well as proteinuria over 300 mg/24 hours or protein to creatinine ratio greater than 0.3. Women with preeclampsia without severe features are managed with delivery at 37 weeks. If diagnosed before 37 weeks, they are closely monitored as inpatients, although outpatient monitoring can be utilized if there are no other comorbidities. To be diagnosed as preeclampsia with severe features, blood pressure must be greater than 160/110 mm Hg in addition to proteinuria. Alternatively, blood pressure can be greater than 140/90 mm Hg on two occasions with at least one other feature, including renal insufficiency, thrombocytopenia, pulmonary edema, impaired liver function, or cerebral or visual disturbances. These patients should be delivered at 34 weeks and should receive treatment with magnesium sulfate for seizure prophylaxis. If blood pressure is greater than 160/110 mm Hg, antihypertensives should be used to decrease the risk of stroke.[13][14]Approximately 10% of patients with preeclampsia with severe features will go on to develop HELLP syndrome—these patients present with hemolysis, elevated liver enzymes, and low platelets. Hypertension and proteinuria do not need to be present in these patients. These patients diagnosed after 34 0/7 weeks should be delivered once stabilized. If diagnosed before 34 weeks, these women should be delivered 24 to 48 hours after betamethasone administration. They should also be administered magnesium sulfate until 24 hours postpartum.[15][14]Eclampsia is diagnosed when grand mal seizures occur in a preeclamptic patient. It can occur in women both with and without severe features. Eclampsia appears to occur when there is a breakdown in autoregulation of cerebral circulation due to endothelial dysfunction, hyperperfusion, and brain edema. Treatment includes seizure management and prophylaxis, blood pressure control, and delivery once the patient has been stabilized and convulsions controlled.[14]Placenta previa occurs with abnormal implantation of the placenta covering the internal cervical os. It can be considered complete, in which the internal os is completely covered by the placenta, partial previa, with the placenta covering a portion of the internal os, or marginal previa, where the edge of the placenta approaches the margin of the os. The placenta is considered low-lying when it is in the lower uterine segment but does not extend to the internal os. During the third trimester, the lower uterine segment begins thinning, leading to disruption in the placental attachment and painless bleeding. This bleeding irritates the uterus, stimulating uterine contractions that cause further separation and bleeding. As the cervix dilates and effaces during labor, placental separation and unavoidable bleeding occur, which may result in hemorrhage and shock. These patients are managed with pelvic rest after 20 weeks, decreased physical activity, and cesarean delivery between 36 and 37 weeks.[16]Placenta accreta occurs when the placenta invades into the uterine wall during implantation. If the invasion extends to the myometrium, the term for the condition is placenta increta. If the invasion extends further through the myometrium and into the serosa, this is considered placenta percreta. Placenta percreta may also invade into surrounding organs, such as the bladder or rectum. In these conditions, the placenta is unable to separate from the uterine wall properly, which can lead to hemorrhage and shock. As such, this condition can lead to the need for a hysterectomy at the time of delivery.[17]Understanding changes that occur during pregnancy is critical for the proper management of pregnant patients. They encounter many physical changes that can create physical, mental, and emotional strain for the patient. It is essential to remain sensitive to these changes when providing care.In addition to remaining sensitive to providing compassionate care, knowing the physiologic changes of pregnancy are essential when determining whether an apparent pathology is indeed pathological versus a normal finding in a pregnant patient. Many lab value limits are adjusted in pregnancy due to the changes in hormones and organ functioning. Hypotension and tachycardia become more prevalent throughout pregnancy, requiring careful considerations in the treatment of a pregnant trauma patient.Overall, understanding the physiology of pregnancy allows all providers, not only OB/GYNs, to provide the best possible care.Review Questions1.Creanga AA, Berg CJ, Ko JY, Farr SL, Tong VT, Bruce FC, Callaghan WM. Maternal mortality and morbidity in the United States: where are we now? 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Placenta Accreta Spectrum: A Review of Pathology, Molecular Biology, and Biomarkers. Dis Markers. 2018;2018:1507674. [PMC free article: PMC6051104] [PubMed: 30057649] Disclosure: Zoey Pascual declares no relevant financial relationships with ineligible companies. Disclosure: Michelle Langaker declares no relevant financial relationships with ineligible companies. If you've just found out you're pregnant, one of the first questions you'll have is: How far along am I? Beyond knowing that all-important due date, knowing how many weeks pregnant you are will help you better track those pregnancy milestones along the way.How Can I Calculate How Far Along I Am and My Due Date?If you know the date of the first day of your last menstrual period, or the date of conception, the easiest way to get an estimate of how far along you are is by using our Pampers due date calculator. Keep in mind that your healthcare provider will be able to give you a more accurate answer at your first prenatal care appointment. Keep in mind that your healthcare provider will be able to give you a more accurate answer at your first prenatal care appointment.There are several different ways to figure out your due date and gauge how far along you are.Last menstrual period (LMP): Pregnancy normally lasts about 40 weeks from the first day of your last period. Accordingly, the number of weeks that have passed since indicates what week of pregnancy you're in. To work out your likely due date, count 280 days (40 weeks) from the first day of your last period.Date of conception: You probably conceived around the time of ovulation, which is around day 14 of the average menstrual cycle of 28 days. If you happen to know the exact date, count 266 days (38 weeks) to get an estimate of your due date. Alternatively, head to the Pampers due date calculator, where all the counting will be done for you.Ultrasound: At some point during your pregnancy, you will likely have an ultrasound scan. This enables your healthcare provider to check on fetal growth and monitor other development milestones; it also provides the most accurate estimate for how many weeks pregnant you are and what your due date will be. This method is the most reliable, and particularly useful if you don't know the date of your last period or if your menstrual cycles are irregular.When figuring out how far along you are, it can be confusing that the weeks of pregnancy are not the same as the gestational age of the baby. Remember, conception most likely occurred about 14 days into your last cycle, whereas pregnancy is calculated from the beginning of that cycle, so there's a two-week difference. For example, when you're 6 weeks pregnant, your baby's gestational age is only four weeks. During your prenatal checkups, your healthcare provider will monitor how far along you are. Don't be surprised, though, if your provider gives you a slightly different due date than the one you calculated.Also, most babies don't arrive exactly on their due date. Every pregnancy is unique, and only a small percentage of babies are born right on time. Babies are typically born between weeks 38 and 42, and it's normal for your baby to arrive any time during this window.If your baby is born pre-term, your doctor will be able to advise you on any extra care your baby might need. On the other hand, if your baby isn't born by the end of week 42, your doctor may suggest inducing the labor to bring on a vaginal birth, or he may discuss the option of a cesarean section with you.Now that you know how far along you are, it might be helpful to know that pregnancies are often referred to in weeks and trimesters. Take a look at this pregnancy timeline for a breakdown of the weeks, months, and trimesters of pregnancy:Here are some of the things you can expect in each trimester:First trimester (weeks 0-13): You might notice some early signs of pregnancy, such as morning sickness and food cravings. Your provider will be able to confirm your pregnancy and set up your prenatal visits to make sure you and your baby stay healthy and safe.Second trimester (weeks 14-27): This trimester is often referred to as the honeymoon phase of pregnancy. You may feel as if you have some extra energy to get things done, like baby-proofing your home, going to prenatal classes, and doing some gentle pregnancy exercise.Third trimester (weeks 28-42): You're nearly there! As you get closer to the birth of your baby, you'll want to get prepared by making sure you have all the right baby gear. But remember to take the opportunity to slow down and rest whenever you can.Now that you've learned how to know how far along you are and what important milestones await you during your pregnancy, remember that your baby will be here soon, and a new, exciting chapter is about to begin.Bottom lineNow that you've learned how to calculate how far along you are and what important milestones await you during your pregnancy, remember that your baby will be here before you know it—and a new, exciting chapter is about to begin.For tips, tools, and rewards along the way, download the Pampers Rewards App to earn Pampers Cash on your diaper purchases and get personalized content for every stage of your journey. , the free encyclopedia that anyone can edit. 117,922 active editors 6,999,121 articles in English An RATP Group electric Heuliez Bus shuttles athletes from the Olympic Village. Transportation during the 2024 Summer Olympics and Paralympics constituted a major challenge for the organisers due to the scale of the event. Over €500 million was invested in improvements to transportation infrastructure for the games. A mobile app was developed to facilitate travel by offering a route calculator, and 5,000 agents were deployed at stations and bus stops to assist travellers. A goal of Paris 2024 was to halve the average carbon footprint of the London 2012 and Rio 2016 games. The organisers estimated that more than a third of the greenhouse gas emissions would be from the transport of athletes and spectators. All venues were made accessible by public transport and bicycle, with 415 kilometres (258 mi) of cycle paths created to link the venues and 27,000 bicycle racks installed. Public transport was extended and services increased. The goal was met, with an estimated 54.6% reduction, representing 1.59 million tonnes of CO2 equivalent. (Full article...) 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Ongoing: Gaza war M23 campaign Russian invasion of Ukraine timeline Sudanese civil war timeline Recent deaths: Jim Irsay Yury Grigorovich Yuri Vladimirov Colton Ford Werenoi Benjamin Ritchie Nominate an article May 26: Memorial Day (2025) in the United States; National Sorry Day in Australia; Independence Day in Georgia (1918) Damage to the Interstate 40 bridge 1644 – Portuguese Restoration War: Portuguese and Spanish forces both claimed victory at the Battle of Montijo. 1894 – Germany's Emanuel Lasker defeated Wilhelm Steinitz to become the world chess champion, beginning a record 27-year reign. 1999 – Manchester United won the UEFA Champions League final to become the first English football club to win three major championships in the same season. 2002 – Barges being towed destroyed part of a bridge (aftermath pictured) near Webbers Falls, Oklahoma, causing vehicles to fall into the Robert S. Kerr Reservoir on the Arkansas River. Augustine of Canterbury (d. 604)Isaac Franklin (b. 1789)Jeremy Corbyn (b. 1949)Elizabeth Peer (d. 1984) More anniversaries: May 25 May 26 May 27 Archive By email List of days of the year About Tom Cruise Top Gun: Maverick, a 2022 American action drama film directed by Joseph Kosinski, garnered accolades in a variety of categories, with particular recognition for Tom Cruise's (pictured) performance as well as its sound and visual effects, cinematography, and film editing. It received six nominations at the 95th Academy Awards, including Best Picture, and won Best Sound. At the 76th British Academy Film Awards, The film was nominated for Best Cinematography, Best Editing, Best Sound, and Best Special Visual Effects. Maverick received six nominations at the 28th Critics' Choice Awards and won Best Cinematography. It garnered two nominations at the 80th Golden Globe Awards. In addition to two National Board of Review Awards, Maverick was named one of the ten-best films of 2022 by the American Film Institute. (Full list...) Recently featured: National preserve 76th Primetime Emmy Awards Historic places in Mackenzie District Archive More featured lists The bluespotted ribbontail ray (Taeniura lymma) is a species of stingray in the family Dasyatidae. Found from the intertidal zone to a depth of 30 m (100 ft), this species is common throughout the tropical Indian and western Pacific Oceans in nearshore, coral reef-associated habitats. It is a fairly small ray, not exceeding 35 cm (14 in) in width, with a mostly smooth, oval pectoral fin disc, large protruding eyes, and a relatively short and thick tail with a deep fin fold underneath. It can be easily identified by its striking color pattern of many electric blue spots on a yellowish background, with a pair of blue stripes on the tail. This bluespotted ribbontail ray was photographed in the Red Sea off the coast of Egypt. Photograph credit: Diego Delso Recently featured: Black Lives Matter art Germanicus The Cocoanuts Archive More featured pictures Community portal – The central hub for editors, with resources, links, tasks, and announcements. Village pump – Forum for discussions about Wikipedia itself, including policies and technical issues. Site news – Sources of news about Wikipedia and the broader Wikimedia movement. Teahouse – Ask basic questions about using or editing Wikipedia. Help desk – Ask questions about using or editing Wikipedia. Reference desk – Ask research questions about encyclopedic topics. Content portals – A unique way to navigate the encyclopedia. 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Many other Wikipedias are available; some of the largest are listed below. 1,000,000+ articles العربية Deutsch Español فارسی Français Italiano Nederlands 日本語 Polski Português Русский Svenska Українська Tiếng Việt 中文 250,000+ articles Bahasa Indonesia Bahasa Melayu Bân-lâm-gú Български Català Čeština Dansk Eesti Ελληνικά Esperanto Euskara עברית Հայերեն Magyar Norsk bokmål Română Simple English Slovenčina Srpski Srpskohrvatski Suomi Türkçe Oʻzbekcha 50,000+ articles Asturianu Azərbaycanca [illegible] Bosanski کوردی Frysk Gaeilge Galego Hrvatski ქართული Kurdî Latviešu Lietuvių [illegible] Македонски [illegible] Norsk nynorsk [illegible] Shqip Slovenščina [illegible] اردو Retrieved from " 2Award ceremony for films of 2022 "Oscars 95" redirects here. For the cere held in 1995, see 67th Academy Awards. For the ceremony for films released in 1995, see 68th Academy Awards. 95th Academy AwardsOfficial posterDateMarch 12, 2023SiteDolby TheatreHollywood, Los Angeles, California, U.S.Hosted byJimmy KimmelPreshow hosts Ashley Graham Vanessa Hudgens Lilly Singh[1] Produced by Glenn Weiss Ricky Kirshner Directed byGlenn WeissHighlightsBest PictureEverything Everywhere All at OnceMost awardsEverything Everywhere All at Once (7)Most nominationsEverything Everywhere All at Once (11)TV in the United StatesNetworkABCDuration3 hours, 37 minutes[2]Ratings 18.75 million[3] 9.9% (Nielsen ratings) ← 94th Academy Awards 96th → The 95th Academy Awards ceremony, presented by the Academy of Motion Picture Arts and Sciences (AMPAS), took place on March 12, 2023, at the Dolby Theatre in Hollywood, Los Angeles. During the gala, the AMPAS presented Academy Awards (commonly referred to as Oscars) in 23 categories honoring films released in 2022. The ceremony, televised in the United States by ABC, was produced by Glenn Weiss and Ricky Kirshner, with Weiss also serving as director. Comedian Jimmy Kimmel hosted the show for the third time, following the 89th ceremony in 2017 and the 90th ceremony in 2018.[4] In related events, the Academy held its 13th annual Governors Awards ceremony at the Fairmont Century Plaza Hotel in Century City, California, on November 19, 2022. The Academy Scientific and Technical Awards were presented by host Simu Liu on February 24, 2023, in a ceremony at the Academy Museum of Motion Pictures in Los Angeles.[5] Everything Everywhere All at Once won seven awards, including Best Picture.[6][7] Other winners included All Quiet on the Western Front with four awards, The Whale with two, and Avatar: The Way of Water, Black Panther: Wakanda Forever, The Boy, the Mole, the Fox and the Horse, The Elephant Whisperers, Guillermo del Toro's Pinocchio, An Irish Goodbye, Navalny, RRR, Top Gun: Maverick, and Women Talking with one. The telecast drew 18.75 million viewers in the United States.[3] The nominees for the 95th Academy Awards were announced on January 24, 2023, at the Samuel Goldwyn Theater in Beverly Hills, by actors Riz Ahmed and Allison Williams.[8] Everything Everywhere All at Once led all nominees with eleven nominations; All Quiet on the Western Front and The Banshees of Inisherin tied for second with nine nominations each.[9][10] The winners were announced during the awards ceremony on March 12, 2023. Everything Everywhere All at Once became the first science fiction film to win Best Picture,[11] and became the third film, alongside A Streetcar Named Desire (1951) and Network (1976), to win three acting awards.[12] Best Director winners Daniel Kwan and Daniel Scheinert became the third pair of directors to win for the same film.[a] For the first time since the 7th ceremony in 1935, all five Best Actor nominees were first-time nominees.[13] Michelle Yeoh became the first Asian winner for Best Actress and the second woman of color overall after Halle Berry, who won for her performance in Monster's Ball (2001).[14] Furthermore, she became the first woman to identify as Asian to be nominated in that category.[b] Ke Huy Quan became the first Vietnamese person to win an Oscar and the second Asian winner for Best Supporting Actor after Haing S. Ngor, who won for his role in The Killing Fields (1984).[15][16] The 42-year span between Judd Hirsch's first nomination, for his supporting role in Ordinary People (1980), and his second, for The Fabelmans, set the record for the longest gap between Oscar nominations.[13] At age 90, Best Original Score nominee John Williams became the oldest person nominated competitively in Oscars history.[13] Best Costume Design winner Ruth E. Carter became the first Black woman to win two Oscars.[17] Daniel Scheinert and Daniel Kwan, Best Picture co-winners, and Best Director and Best Original Screenplay winners Brendan Fraser, Best Actor winner Michelle Yeoh, Best Actress winner Ke

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