FUNCTIONAL AND ESTHETIC REHABILITATION OF PARTIAL EDENTULISM USING DENTAL BRIDGES

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Background. Partial edentulism causes functional and aesthetic imbalances by reducing masticatory efficiency, producing occlusal changes, and affecting aesthetic perception, which frequently motivates patients to seek fixed prosthetic rehabilitation.
Objective of the study: To evaluate the distinctive characteristics of the methods used for functional and aesthetic rehabilitation of partial edentulism by means of dental bridges.
Material and methods. The study had a retrospective design and was conducted at the University Dental Clinic No. 2, Department of dental propedeutics "Pavel Godoroja", during the period 2022–2026, through the analysis of a group of 16 patients with Kennedy Class III partial edentulism treated prosthetically with fixed dental bridges. The evaluation included clinical examination, paraclinical investigations (radiographs and study models), recording the data in the patients' medical records, and the application of a questionnaire to assess patient satisfaction with the rehabilitation.
Results. The retrospective study included 16 patients with partial edentulism rehabilitated with fixed dental bridges, with a mean age of 53 years. All cases were represented by intercalated edentulous spaces of Kennedy Class III and IV, with a predominance of Class III **(**75%) compared to Class IV (25%). Clinical and radiological examination revealed favorable conditions of the abutment teeth and appropriate marginal adaptation of the prosthetic restorations, without immediate complications. The level of patient satisfaction was high: 81.25% declared themselves very satisfied with the treatment, 87.5% reported an improvement in masticatory function, and 75% considered the aesthetic outcome to be very satisfactory. The results indicate the effectiveness of fixed dental bridges in the functional and aesthetic rehabilitation of intercalated edentulous spaces.
Conclusions. Rehabilitation of Kennedy Class III partial edentulism with fixed dental bridges remains a frequently applied option aimed at restoring function and aesthetics, with the need for post-therapeutic monitoring and preventive measures to maintain periodontal health and reduce caries recurrence.
Keywords: dental bridge, masticatory performance, zirconia, aesthetics, complications.

Background

The loss of one or more teeth leads to functional and aesthetic imbalances with a major impact on both oral and general health. Partial edentulism affects mastication, phonation, lip support, and the facial profile, as well as the patient's psychosocial status, often generating embarrassment in interpersonal relationships and a reduced quality of life. The selection of an optimal prosthetic solution should be based on a balanced relationship between functional, aesthetic, biological, and financial requirements [4].

Fixed dental bridges represent a classical treatment option in partial edentulism, particularly in situations where the remaining teeth can provide adequate support and when the patient prefers a non-removable

rehabilitation. In many cases, they represent the first treatment option for the rehabilitation of partial edentulism, the choice being influenced by the degree of edentulism, the distribution of edentulous spaces, the quality and number of abutment teeth, as well as the patient's expectations [1].

In the national literature, dental bridges with odonto-periodontal support are described as fixed gnathoprosthetic appliances, permanently attached to the abutment teeth, which ensure a physiological transmission of masticatory forces to the alveolar bone and provide a high level of functional comfort due to their reduced volume and stability, being appreciated by the majority of patients [4].

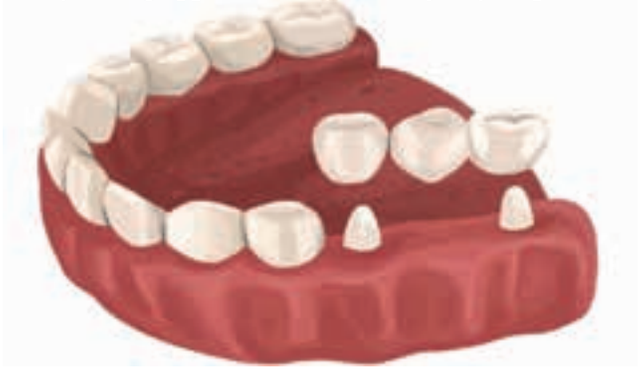

Figure 1. *Schematic representation of a conventional three-unit dental bridge used for single-tooth replacement, consisting of two prepared abutment teeth and an intermediate pontic [6].*

However, the literature emphasizes that the fabrication of these prosthetic constructions involves a significant sacrifice of coronal tooth structure at the level of the abutment teeth and is associated with an increased risk of pulpal complications and marginal secondary caries. This explains the relatively higher long-term rate of abutment tooth loss (8–18% over approximately 10 years) and highlights the need to reconsider the indications for conventional bridges in favor of implant-prosthetic solutions in cases of single-tooth edentulism [6].

Objective of the study

The aim of the study is to evaluate the distinctive characteristics of the methods used for the functional and aesthetic rehabilitation of partial edentulism using dental bridges, by integrating data from the scientific literature with the results of retrospectively analyzed clinical observations.

Objectives

1. Evaluation of data from the specialized literature regarding the efficiency of the functional and aesthetic rehabilitation of partial edentulism using fixed dental bridges.
2. Comparative analysis of the materials and techniques used in the fabrication of fixed dental bridges, highlighting their influence on marginal adaptation, mechanical strength, durability, and the aesthetic outcome of prosthetic restorations.
3. Evaluation of the clinical, functional, and aesthetic outcomes of prosthetic treatment with dental bridges in patients with Kennedy Class III and IV partial edentulism, in order to assess the impact on masticatory function and patients' quality of life.

Materials and Methods

The study was conducted during the period 2022–2026 at University Dental Clinic No. 2, within the Department of Dental Propedeutics "Pavel Godoroja".

In order to evaluate the efficiency of the functional and aesthetic rehabilitation of partial edentulism using fixed dental bridges, a narrative review of the specialized literature was performed. Scientific articles published in international databases such as PubMed, ScienceDirect, and Google Scholar were analyzed, addressing the treatment of partial edentulism through fixed prosthetic restorations.

In addition to the literature review, a retrospective study was conducted based on the evaluation of the medical records of patients treated with fixed prosthetic restorations. The study material included patients' medical records and clinico-paraclinical data, supplemented by radiographs and study models, used for establishing the diagnosis and prosthetic treatment indication. Furthermore, a questionnaire was developed and administered to collect data regarding patients' perception and satisfaction with the prosthetic rehabilitation. From the total number of available cases, 16 clinical records of patients diagnosed with partial edentulism and rehabilitated with fixed dental bridges were selected. For each case, several criteria were analyzed: patients' age and sex, the location of the edentulous space, the dental arch involved (maxillary or mandibular), as well as the type of material used for the prosthetic restoration. The obtained data were analyzed descriptively in order to highlight the main characteristics of the performed prosthetic restorations.

Results and Discussion

Partial edentulism can be classified according to the position and extent of the edentulous spaces, for example by the Kennedy classification or by the number of lost occlusal units. The presence of edentulous spaces bounded by teeth on both sides represents the ideal situation for a conventional fixed dental bridge supported by abutment teeth. In contrast, extensive distal edentulous spaces (unilateral or bilateral) require careful analysis of the crown–root ratio, the length of the edentulous span, and the possibilities for additional support (particularly implants) [5].

The major indications for dental bridges include: the need to rehabilitate a limited edentulous space; the presence of abutment teeth with favorable root and periodontal support; and the patient's preference for a fixed solution. Relative contraindications include an unfavorable crown–root ratio, severe periodontal attachment loss, pronounced tooth mobility, poor oral hygiene, and uncontrolled bruxism [1].

The biomechanical design of a fixed dental bridge aims to transform masticatory forces into loads that are as axial as possible on the abutment teeth and to reduce bending or torsional moments that may lead to decementation, fractures, and periodontal overload [26].

The design of the pontic, the minimum thickness of the material, the extension of the pontic units, and occlusal control are important parameters. In the case of monolithic zirconia, the minimum thickness may be reduced compared with metal–ceramic restorations due to the increased fracture resistance of the material [3].

Materials used in fixed dental bridges

Metal–ceramic restorations (metal framework with veneering ceramic) remain the "reference" material in fixed dental bridges, with high success rates reported in literature reviews. The complication profile is mainly related to chipping or fracture of the veneering material and, more rarely, other technical failures [7].

All-ceramic restorations, particularly bridges based on zirconium oxide, are presented as a modern alternative with comparable survival in many situations; however, they are associated with more frequent technical complications, which requires careful selection of the ceramic system and the clinical indication [7].

Fracture of the veneering ceramic has been reported in 2.7% of metal–ceramic restorations and in 6.4% of zirconia-based restorations, without being considered failures, while the plaque index was more favorable for zirconia bridges. In a prospective pilot study that followed posterior bridges made of monolithic zirconia for 3 years, the survival rate was 100%, with no mechanical complications and only three biological complications that were easily managed [9].

For zirconia, the literature also notes a specific material-related aspect: the risk of low-temperature degradation, which should be considered when selecting the type of zirconia and the clinical indication [7].

Resin-bonded fixed bridges represent a modern and more conservative solution, described as a long-term provisional restoration, with better performance particularly in the anterior region, where the key material is the adhesive system or resin cement [7].

Fiber-reinforced composite materials and inlay-supported bridges are mentioned as modern options, but with a more compromised long-term prognosis compared with conventional bridges [7].

Functional rehabilitation through fixed dental bridges aims to restore occlusal support in the posterior regions, stabilize dental contacts, and harmonize intermaxillary relationships in order to ensure efficient mastication. Properly restored occlusion contributes to the balanced distribution of masticatory forces, preventing local overload and reducing the risk of the development or aggravation of neuromuscular dysfunctions of the dento-maxillary system. The scientific literature emphasizes that the success of fixed prosthetic restorations largely depends on the accurate recording of intermaxillary relationships and on the careful verification of occlusal contacts both in the maximum intercuspal position and during eccentric movements. These steps are essential for achieving a stable and functional occlusal scheme in the long term [20].

A study conducted on patients with partial edentulism showed that rehabilitation with fixed prosthetic restorations, mainly dental bridges, leads to an average increase in masticatory performance of approximately 20% (range 17–25%), with the occlusal contact area increasing by 4.7 mm², and patient satisfaction with mastication increasing by approximately 9% three months after prosthesis insertion [16].

In clinical practice, the control of occlusal stability is complemented by the management of occlusal disharmonies (including situations where signs of temporomandibular disorders – TMD are present), through differential diagnosis and corrective measures, following established educational and clinical protocols [24].

The esthetic integration of a dental bridge is not limited to shade selection; it also involves the coherent reconstruction of dental form and its relationship with the lips and surrounding soft tissues. In cases of limited partial edentulism, semi-physiognomic bridges are described as solutions aimed at achieving an appearance as close as possible to natural dentition, through the proper modeling of the vestibular surfaces, cervical transition areas, and interdental contacts [2,13]. The pontic design, through the selection of its morphology and the conditioning of the soft tissues, allows the achievement of more natural cervical contours and a smoother transition between the restoration and the alveolar ridge, with a direct impact on esthetic perception during smiling [10].

The selection of the material and technology should be made according to the esthetic requirements and the region of the dental arch. In recent years, zirconia with improved optical properties has been discussed as an option for fixed restorations with increased esthetic demands [9,12]. Clinical data regarding monolithic zirconia restorations fabricated using CAD/CAM technology show favorable results, which supports their use when a balance between esthetics and clinical predictability is desired [15]. In the anterior region, when a more conservative approach is sought, adhesive (resin-bonded) bridges (including all-ceramic ones) are described as minimally invasive solutions, useful in selected cases, provided that strict control of the indication and occlusion is maintained [5,11]. Additionally, digital workflows (scanning, design, mock-ups/guides, prototypes) support dentist–laboratory communication and the pre-visualization of the esthetic outcome before finalization of the restoration [18].

Patient satisfaction is a major indicator of the success of prosthetic rehabilitation. Satisfaction reflects both the clinical outcome (marginal adaptation, occlusion, structural integrity) and the way the patient perceives mastication, comfort, esthetics, and ease of oral hygiene. In cases of partial edentulism, rehabilitation with conventional prostheses (including fixed dental bridges when indicated) is associated with an improvement in masticatory performance and an increase in self-reported satisfaction with mastication during the post-insertion follow-up period. This supports the positive impact of treatment on function and on oral health-related quality of life [16]. Recent data indicate that, in partial edentulism, the selected prosthetic method may influence both the parameters of oral hypofunction and the quality-of-life scores, which justifies the individualization of the prosthetic indication and design [16].

In current clinical practice, medium- and long-term patient satisfaction depends on correct case selection, occlusal control, and the stability of the prosthetic restoration, as well as on the real possibilities for hygiene under the pontic and around the abutment teeth, and on the frequency of complications and the need for maintenance. Patient satisfaction should be interpreted in the context of available treatment alternatives.

Reviews regarding removable partial dentures show that patients may report good levels of satisfaction; however, aspects related to stability, comfort, and adaptation may vary, which explains the frequent preference for fixed solutions when biological indications and clinical conditions allow it [1].

In prosthetic practice, complications of dental bridges occur through the interaction between iatrogenic factors and endogenous factors. Studies emphasize that the prevention of complications begins at the stage of diagnosis, treatment planning, and proper occlusal integration of the restoration, since edentulism and its rehabilitation are associated with functional disturbances that may involve the masticatory muscles and the temporomandibular joint (TMJ) when occlusal stability is compromised [21,26].

During clinico-radiological evaluations performed on patients treated with dental bridges, marginal secondary caries, cervical caries, or the progression of incipient carious lesions that were not identified at the time of treatment are frequently reported [4]. Biological complications include pain and pulpal involvement, as well as chronic apical periodontitis resulting from incorrect root canal treatments [4]. The national literature also emphasizes that the conventional bridge may lead to the deterioration and compromise of the teeth adjacent to the edentulous space, which justifies careful case selection and the most conservative approach possible [6].

Sources indicate that instability of static and dynamic occlusal positions may manifest through morpho-functional disturbances of the neuromuscular complex and the temporomandibular joint, confirmed by clinical-instrumental and imaging investigations. For this reason, treatment planning is based on occlusal rebalancing and the maintenance of occlusal stability [21]. In the same context, USMF methodological materials highlight that partial edentulism may be associated with functional overload and disturbances in the masticatory musculature and the temporomandibular joint, while treatment with dental bridges also aims at the prevention of tooth migration and functional overload [26].

For metal-free adhesive bridges, national authors explicitly emphasize that success depends on the condition of the adjacent teeth, favorable interocclusal relationships, the absence of parafunctions (bruxism), and proper oral hygiene. Failure to comply with these conditions increases the probability of complications and the functional failure of the restoration [23].

The retrospective study included a group of 16 patients with partial edentulism, in whom prosthetic treatment was performed using fixed dental bridges. The analysis of the cases was based on the evaluation of medical records, clinical and paraclinical data, radiographs, and study models, used to establish the diagnosis and to plan the prosthetic treatment.

From a demographic perspective, the cases were more frequently identified in middle-aged patients, the mean age of the group being 53 years, with a predominant concentration in the 50–69-year age range. This distribution is consistent with the progression over time of dental caries and periodontal complications, which are etiological factors frequently involved in the occurrence of partial edentulism.

With regard to the classification of edentulism according to Kennedy, all cases included in the study were represented by intercalated edentulous spaces, without the presence of distal (terminal) edentulous spaces. Thus, Kennedy Class III and Kennedy Class IV edentulism were identified, which are considered favorable for rehabilitation with fixed dental bridges due to the presence of abutment teeth located anterior and posterior to the edentulous space.

The distribution of cases showed a predominance of Kennedy Class III edentulism, identified in 12 patients (75%), while Kennedy Class IV edentulism was observed in 4 patients (25%). The localization of the edentulous spaces was observed both in the maxillary arch and in the mandibular arch, without major differences in frequency.

Clinical and radiological examination revealed that the abutment teeth selected to support the dental bridges presented adequate periodontal support, without significant pathological mobility and without active periapical lesions. The analysis of the study models allowed the evaluation of the available prosthetic space,

occlusal relationships, and interdental relationships, facilitating the selection of the optimal prosthetic solution for each case.

The evaluation of the prosthetic restorations demonstrated adequate marginal adaptation and satisfactory stability of the fixed dental bridges, without immediate clinical complications after the insertion of the prosthetic restorations. From a functional perspective, prosthetic rehabilitation with fixed dental bridges contributed to the restoration of dental arch continuity, the improvement of occlusal stability, and the optimization of masticatory performance, while also producing a favorable esthetic effect on the patients' dento-facial appearance.

The results of the questionnaire administered to the patients revealed a high level of satisfaction with the prosthetic treatment. Thus, 13 patients (81.25%) declared themselves very satisfied with the obtained results, 2 patients (12.5%) reported a good level of satisfaction, while 1 patient (6.25%) indicated a moderate level of satisfaction, mentioning a longer adaptation period to the prosthetic restoration.

Additionally, 14 patients (87.5%) reported a significant improvement in masticatory function, while 12 patients (75%) considered the esthetic outcome to be very satisfactory, highlighting the positive impact of prosthetic rehabilitation on the functionality of the dento-maxillary system and on patient comfort.

Overall, the results of the study indicate that the treatment of intercalated Kennedy Class III and IV edentulism with fixed dental bridges provides favorable clinical outcomes, contributing to the restoration of masticatory function, occlusal stability, and dental esthetics, as well as to an increased level of patient satisfaction.

Based on data from the specialized literature and on the principles applied in prosthetic practice, the following clinical recommendations may be formulated for the rehabilitation of partial edentulism with fixed dental bridges:

1. Occlusal planning: accurate recording of intermaxillary relationships and verification of static and dynamic occlusion, with elimination of interferences and premature contacts, especially in cases with tooth migration and occlusal instability [19,20,21,24].
2. Proper biomechanical design: limiting, as far as possible, the extent of edentulous spans and avoiding cantilevers; if a cantilever is unavoidable, occlusal contacts on the cantilever segment must be strictly controlled, and the patient must be monitored more frequently [8,22].
3. Connectors and rigidity: connectors should be dimensioned so as to ensure rigidity, with smooth transitions (without areas of stress concentration); in monolithic zirconia bridges, connector design and dimensions are critical factors for fracture resistance [14].
4. Finishing and cementation: the cement should be selected according to the material and the retentiveness of the preparation; after occlusal adjustments, the surfaces should be polished to limit plaque retention and wear of the opposing dentition [24,7].
5. Conservative indications (adhesive bridges): in selected cases of single-tooth edentulism, especially in the anterior region, adhesive bridges may represent a minimally invasive option, but success depends strictly on case selection, occlusion, and adhesive technique [23,25,7].
6. Post-treatment monitoring: periodic follow-up examinations should be scheduled, including verification of occlusion, marginal integrity, oral hygiene, and supporting tissues, for the early detection of biological and technical complications [24,26].

Conclusions

1. The review of the specialized literature highlighted that the functional and esthetic rehabilitation of partial edentulism through dental bridges represents an effective therapeutic method with predictable outcomes when it is correctly indicated and performed in accordance with the clinical characteristics of each patient. The retrospective study allowed the synthesis of clinical data from 16 medical records of patients with Kennedy Class III and IV partial edentulism during the period 2022–2026, highlighting

the practical value of fixed prosthetic rehabilitation in lateral edentulous spaces bounded by natural teeth.

2. The comparative analysis of the methods used for the fabrication and application of fixed dental bridges demonstrated that the selection of materials and fabrication techniques significantly influences the durability, marginal adaptation, mechanical strength, and esthetic appearance of the prosthetic restoration, emphasizing the need for individualization of the treatment plan.
3. The evaluation of the clinical, functional, and esthetic outcomes confirms that dental bridges contribute to the effective rehabilitation of masticatory function, phonetics, and facial harmony, considerably improving the quality of life of patients with partial edentulism.

Bibliography

27. Awawdeh, M., Alotaibi, M. B., Alharbi, A. H., Alnafisah, A., Alasiiri, T. S., & Alrashed, I. B. (2024). A systematic review of patient satisfaction with removable partial dentures (RPDs). Cureus, 16(1), e51793. https://doi.org/10.7759/cureus.51793
28. Buga, D., Gribenco, V., Fachira, A. - *Tabloul clinic şi tratamentul edentaţiilor parţiale reduse cu punţi dentare semifizionomice* (2015). https://repository.usmf.md/bitstream/20.500.12710/2242/1/TABLOUL_CLINIC_SI_TRATAMENTUL_EDENTATIILOR_PARTIALE_REDUSE_CU_PUNTI.pdf
29. Ceban, M.*Imobilizarea multidirecţională a dinţilor mobili… (cu referinţe la restaurări conjuncte/punţi dentare şi reechilibrare ocluzală)* (2010). https://ibn.idsi.md/sites/default/files/imag_file/46-48_60.pdf
30. Chele, N. - *Evaluarea clinico-radiologică a pacienţilor cu edentaţie parţială unidentară trataţi cu punţi dentare* (2013). https://repository.usmf.md/bitstream/20.500.12710/22143/1/Evaluarea_clinico_radiologica_a_pacientilor_cu_edentatie_partiala_unidentara_tratati_cu_punti_dentare.pdf
31. Chen J., et al. A Systematic Review of the Survival and Complication Rates of All-Ceramic Resin-Bonded Fixed Dental Prostheses. Journal of Prosthodontics, 2018. https://pubmed.ncbi.nlm.nih.gov/28985448/
32. Cheptanaru O. Tratamentul protetic în edentaţia unidentară. Buletinul Academiei de Ştiinţe a Moldovei. Ştiinţe Medicale. 2015;1:422-428.
33. Cheptanaru, O. - *Tratamentul contemporan al edentaţiilor unidentare* (2019). https://repository.usmf.md/bitstream/20.500.12710/21537/1/1_TRATAMENTUL_CONTEMPORAN_AL_p.10_41.pdf
34. Dupagne L, Fouquet V, Attal J-P. Chairside posterior cantilevered fixed partial denture: Case report. Clinical Case Reports. 2023;11(11):e8252. doi:10.1002/ccr3.8252. PMID:38028055; PMCID:PMC10661376. https://pmc.ncbi.nlm.nih.gov/articles/PMC10661376/
35. Golovatinschi, M., Uncuţa, D., Melnic, S., Cheptanaru, O. - *Aspectele contemporane ale utilizării dioxidului de zirconiu în protetica dentară* (2025). (https://repository.usmf.md/xmlui/handle/20.500.12710/30925
36. Gomez-Meda R., et al. Perio-prosthodontic pontic site management (Part I): pontic design / tissue conditioning. Journal of Esthetic and Restorative Dentistry, 2023. https://www.ovid.com/journals/jerd/abstract/10.1111/jerd.13023~perioprosthodontic-pontic-site-management-part-i-pontic?redirectionsource=fulltextview
37. Gribenco, V. - *Tratamentul edentaţiilor parţiale unidentare prin intermediul restaurărilor protetice adezive* (2014). https://repository.usmf.md/bitstream/20.500.12710/21663/1/Tratamentul_edentatiilor_partiale_unidentare_prin_intermediul_restaurarilor_protetice_adezive.pdf

38. Gribenco, V. - *Tratamentul ortopedic al edentaţiei secundare parţiale* (material științific, RM). https://ibn.idsi.md/sites/default/files/imag_file/93.Tratamentul%20ortopedic%20al%20edentatiei%20secundare%20partiale.pdf
39. Guţuţui, V. - *Evaluarea conceperii comparative a tratamentului edentaţiei parţiale cu punţi dentare semifizionomice* (2014). https://repository.usmf.md/bitstream/20.500.12710/21681/1/Evaluarea_conceperii_comparative_a_tratamentului_edentatiei_partiale_cu_punti_dentare_semifizionomice.pdf
40. Hafezeqoran A, Koodaryan R, Hemmati Y, Akbarzadeh A. Effect of connector size and design on the fracture resistance of monolithic zirconia fixed dental prosthesis. J Dent Res Dent Clin Dent Prospects. 2020;14(4):218-222. doi:10.34172/joddd.2020.039. PMID:33575010; PMCID:PMC7867680. https://pmc.ncbi.nlm.nih.gov/articles/PMC7867680/
41. Konstantinidis, I., Trikka, D., Gasparatos, S., & Mitsias, M. E. (2018). Clinical outcomes of monolithic zirconia crowns with CAD/CAM technology: A 1-year follow-up prospective clinical study of 65 patients. International Journal of Environmental Research and Public Health, 15(11), 2523. https://doi.org/10.3390/ijerph15112523
42. Lopez-Cordon, M. A., Khoury-Ribas, L., Rovira-Lastra, B., Ayuso-Montero, R., & Martinez-Gomis, J. (2024). Improved masticatory performance in the partially edentulous rehabilitated with conventional dental prostheses. Medicina, 60(11), 1790. https://doi.org/10.3390/medicina60111790
43. Morinaga D., et al. Effects of various prosthetic methods for Kennedy Class I partial edentulism on oral hypofunction and oral health-related quality of life. International Journal of Implant Dentistry, 2024. https://link.springer.com/article/10.1186/s40729-024-00555-w
44. Mușet, P., Bajurea, N., Uncuţa, D., Cheptanaru, O.*Materiale 3D printate utilizate pentru restaurările indirecte în protetica dentară* (2025) - înregistrare IBN. https://ibn.idsi.md/sites/default/files/imag_file/109_33.pdf
45. Oineagra, V., Oineagra, V.*Nivelarea planului de ocluzie prin suprasolicitarea funcţională a dinţilor migraţi - posibilităţi. Caz clinic* (2013). https://ibn.idsi.md/sites/default/files/imag_file/504-509.pdf
46. Oineagra, V., Postolachi, I., Oineagra, V. - *Aspecte clinice ale relaţiilor intermaxilare în tratamentul protetic cu punţi dentare* (2009). https://ibn.idsi.md/sites/default/files/imag_file/Aspecte%20clinice%20ale%20relatiilor%20intermaxilare%20in%20tratamentul%20protetic%20cu%20punti%20dentare.pdf
47. Oineagra, V., Solomon, O., Oineagra, V., Rusu, V. - *Edentaţia parţială complicată cu instabilitatea poziţiilor de ocluzie* (2019). https://repository.usmf.md/bitstream/20.500.12710/21533/1/7_EDENTATIA_PARTIALA_COMPLICATA_CU_p.72_82.pdf
48. Pjetursson B. E., et al. All-ceramic or metal-ceramic tooth-supported fixed dental prostheses (FDPs): A systematic review of the survival and complication rates. Dental Materials, 2015. https://pubmed.ncbi.nlm.nih.gov/25935732/
49. Postolachi, A.*Puntea dentară adezivă nemetalică: strategia intervenţiei clinico-tehnice* (2012). https://ibn.idsi.md/sites/default/files/imag_file/92.Puntea%20dentara%20adeziva%20nemetalica.pdf
50. Propedeutica (USMF) - material didactic: *Confectionarea protezelor dentare* (include secțiune despre punți dentare și tratamentul edentației parțiale). https://propedeutica.usmf.md/wp-content/blogs.dir/130/files/sites/130/2018/03/confectionarea-protezelor-dentare.pdf
51. Thoma D. S., et al. A systematic review of the survival and complication rates of resin-bonded fixed dental prostheses (RBBs). (EuropePMC record), 2017. https://europepmc.org/article/med/28191679
52. USMF „Nicolae Testemițanu", Catedra de Stomatologie Ortopedică „Ilarion Postolachi" - *Elaborări metodice la lucrările practice…* (2018). https://stomortopedica.usmf.md/wp-content/blogs.dir/94/files/sites/94/2018/03/a3s6ro.-pdf1.pdf