

Dental Health at the Transition from the Late Antique to the Early Medieval Period on Croatia's Eastern Adriatic Coast

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ABSTRACT Dento-alveolar pathologies: caries, ante mortem tooth loss, abscesses, calculus, alveolar resorption and tooth wear were analysed in two composite skeletal series from Croatia's eastern Adriatic coast (Dalmatia). The first consists of 103 skeletons from seven Late Antique (3rd–6th century AD) sites, the second of 151 skeletons from three Early Medieval (7th–11th centuries AD) sites. As recent bioarchaeological studies (Šlaus, 2008) showed a significant increase of disease loads and trauma frequencies in Dalmatia during the Early Medieval period, the aim of this study was to investigate whether dental health was equally adversely affected by the Late Antique/Early Medieval transition. The results of our analyses show that the frequencies of carious lesions, ante mortem tooth loss, abscesses and alveolar resorption increased significantly during the Early Medieval period, as did the degree of heavy occlusal wear on posterior teeth. These data suggest a change in alimentary habits, with a significantly higher dependence on carbohydrates and a greater reliance on hard, fibrous foods requiring vigorous mastication in the Early Medieval diet. The combination of higher calculus and lower caries rates in the Late Antique series similarly suggests more protein in the Late Antique diet and is, therefore, also consistent with the hypothesised change in alimentary habits. In general (the two exceptions are male caries and female alveolar resorption frequencies) lesion frequencies increased uniformly in both sexes suggesting that the deterioration of dental health during the Early Medieval period equally affected males and females. Cumulatively, the collected data suggest that the political, social, economic and religious changes that characterised the Late Antique/Early Medieval transition in Dalmatia resulted in a clear discontinuity, not only from the cultural, but also from the biological point of view with an evident deterioration of oral health during the Early Medieval period. Copyright © 2010 John Wiley & Sons, Ltd.

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Introduction

The transition from Late Antiquity (3rd–5th centuries AD) to the Early Middle Ages (6th–10th centuries AD) in Croatia has traditionally been described as catastrophic with profound political, cultural and social changes that resulted in the destruction of almost all major Late Antique urban centres, depopulation, famine and the spread of infectious diseases (Rački, 1881; Šišić, 1925). Different types of archaeological and historical data were used to support this assumption.

Archaeological data includes clear evidence for the destruction or abandonment of large urban centres such as *Mursa* (modern Osijek), *Cibalae* (Vinkovci), *Salona* (Solina), *Narona* (Vid) and numerous others. At the same time most Roman town names were replaced by Slavic names. Historical sources document numerous, generally short-termed, barbarian invasions (perpetuated in chronological order by the Goths, Huns, Lombards and Gepides), as well as the efforts of the Church to ransom captive Christians, and more importantly, stolen relics from the invading barbarians. After the 6th century Croatia was settled by various Slavic populations, including the Croats who migrated to this area probably in the beginning of the 7th century (Budak, 1994).

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The dramatic nature of this transition was by no means exclusive to Croatia. Archaeological, historical and demographic data suggest that similar changes affected all parts of the Western Roman Empire. There is, for instance, evidence that epidemics, famines, invasions and wars decreased the Italian population from about eight million in the 3rd century, to just over four million in the period from 6th to 9th centuries (Del Panta *et al.*, 1996).

In the last couple of decades Croatian historians have, however, begun pointing out important weaknesses and inconsistencies in the available data that allowed them to gain an appreciation of the complex nature of the Late Antique/Early Medieval transition (Gunjača, 1973; Budak, 1994; Goldstein, 1995). Among them are: (a) a lack of reliable historical sources caused by the fact that Early Croats left no written records meaning that the available sources for the transition are reports made by Frankish, Byzantine or Church historians that are either biased because of various local considerations (for instance Church historians found it impossible to be objective as the arrival of the pagan Croats interrupted and reversed two and a half centuries of Church development), or simply uninterested; (b) the retention of some Roman town names and (c) and the absence of the development of new urban centres in the Adriatic islands populated by Roman refugees fleeing from their destroyed cities. Therefore, while supporting in general the assumption that the transition from the Late Antique to the Early Medieval period in Croatia was characterised by profound political, social and cultural change, some historians suggest a more complex transition.

So far, few bioarchaeological studies have addressed this transition and the potential effects it had on population biology. Analyses of dento-alveolar lesions in the Tyrrhenian region of central Italy between two Roman Imperial age (1st–3rd centuries AD) samples and a Medieval sample from the Lombard era (7th century AD) showed a significant increase of caries, alveolar abscesses and ante mortem tooth loss in the Lombard sample suggesting a deterioration of living conditions with the transition to the Medieval period (Manzi *et al.*, 1999). In contrast to this, analyses of dento-alveolar pathologies, cribra orbitalia and periostitis frequencies between a Late Antique (1st–4th centuries AD) and an Early Medieval (7th century AD) sample from the Molise region in central Italy showed substantial continuity of dietary habits and ways of exploiting the meagre territorial resources (Belcastro *et al.*, 2007). In these samples ecological factors seemed to have affected living conditions considerably more

than the cultural, social and economic changes that followed the fall of the Western Roman Empire (Belcastro *et al.*, 2007).

The situation in Croatia is additionally complicated by the fact that within the administrative framework of the Roman Empire the territory of modern Croatia was divided into two provinces: Pannonia in the continental part of Croatia, and Dalmatia along the eastern Adriatic coast. These two provinces are separated by the massive Dinarid mountain range that forms most of modern Bosnia and Herzegovina, and have significantly different ecological features. Continental Croatia is predominantly flat with numerous rivers and has a continental climate while Dalmatia is characterised by karst formations, few rivers and a Mediterranean climate. Analysis of four markers of health: cribra orbitalia, linear enamel hypoplasia, periostitis and trauma between a large ($n = 477$ skeletons) composite Late Antique series, and a similarly sized composite Early Medieval series ($n = 504$ skeletons) from Croatia highlights the complex nature of this transition. In this dataset the frequencies of the analysed markers of health were similar in continental Croatia, while a significant increase of cribra orbitalia, periostitis and trauma frequencies in the Dalmatian subsample suggests a significant deterioration of living conditions during the Early Medieval period in this part of Croatia (Šlaus, 2008).

Oral pathologies are strongly correlated to subsistence patterns, and as such have been used by numerous researchers to assess diet, food-preparation techniques and through these the quality of life of past populations (Lukacs, 1989; Larsen *et al.*, 1991; Hillson, 1996; Larsen, 1997; Eshed *et al.*, 2006).

Because the analysis carried out by Šlaus (2008) showed a marked deterioration of living conditions during the Early Medieval period in Dalmatia, the aim of this study is to investigate the impact that the Late Antique/Early Medieval transition had on the dental health of the past inhabitants of Dalmatia. To this end the frequencies and distributions of carious lesions, ante mortem tooth loss (AMTL), abscesses, calculus, alveolar resorption and tooth wear are compared in two composite skeletal series from Adriatic Croatia. The first consists of 103 skeletons from seven Late Antique sites, the second consists of 151 skeletons from three Early Medieval sites.

Materials and methods

In this study the dentitions of 254 adult individuals from seven Late Antique and three Early Medieval

Table 1. The age and sex distribution in the analysed sample

| Age (years) | Late Antique | | | Early Medieval | | |
|-------------|-----------------|---------|-------|----------------|---------|-------|
| | Males | Females | Total | Males | Females | Total |
| 18–35 | 16 | 27 | 43 | 28 | 26 | 54 |
| 36+ | 33 | 27 | 60 | 59 | 38 | 97 |
| Total | 49 | 54 | 103 | 87 | 64 | 151 |
| Grand total | | | | | | 254 |
| | Number of teeth | | | | | |
| 18–35 | 377 | 553 | 930 | 665 | 584 | 1249 |
| 36+ | 569 | 493 | 1062 | 925 | 533 | 1458 |
| Total | 946 | 1046 | 1992 | 1590 | 1117 | 2707 |
| Grand total | | | | | | 4699 |

sites were examined. The number of skeletons, sex distribution and number of analysed teeth in the composite series is presented in Table 1. The geographical locations of the analysed sites are shown in Figure 1.

The Late Antique skeletal sample consists of 103 skeletons from seven archaeological sites. All of the sites were urban centres. The analysed material was recovered from: Zadar-Relja, Split-Ad basilicas pictas, Vid (Narona), Podvršje, Krk-Omišalj, Hvar-Dolac and Novigrad. All sites are located along the Eastern Adriatic coast. Their use is dated from 3rd to 6th century AD (Durman, 2006).

The Early Medieval sample consisted of 151 skeletons from three small rural communities located in the hinterland of the Eastern Adriatic coast: Tribalj,

Stranče and Velim. Archaeological material recovered from these sites dates their use to the period between 7th and 11th centuries AD (Cetinić, 1998; Jurić, 2004).

The sex and age of each individual was determined using standard anthropological criteria. Sex determination was based on cranial and pelvic morphology (Phenice, 1969; Bass, 1987; Buikstra & Ubelaker, 1994.). If these elements were missing or poorly preserved discriminant functions for the femur (Šlaus, 1997), and tibia (Šlaus & Tomičić, 2005) developed for antique and medieval Croatian populations were used. Age was estimated using pubic symphysis morphology (Brooks & Suchey, 1990), auricular surface morphology (Lovejoy *et al.*, 1985), ectocranial suture closure (Meindl & Lovejoy, 1985) and sternal rib end changes (Işcan *et al.*, 1984, 1985). All individuals were assigned to one of two composite age categories: younger adults falling between 18 and 35 years, and older adults comprising an open ended 36+ years age category.

There are no significant differences between the two composite series in terms of either the male/female ($\chi^2 = 2.09, p = 0.147$), or young adult/old adult ($\chi^2 = 0.69, p = 0.405$) ratios.

Six dento-alveolar parameters were recorded: caries, AMTL, abscesses, calculus, alveolar bone resorption and tooth wear. Pathologies in the series are analysed by teeth and teeth sockets (alveoli). The denominator will vary depending not only on their presence/absence, but also in the case of calculus and alveolar bone resorption, on the degree of their preservation.

Carious lesions were considered present only if the cavity penetrated the tooth enamel. All teeth were examined macroscopically under a bright light using magnification of up to 10X, and a dental probe was used to eliminate scoring of discoloured intact enamel as carious lesions. The number of lesions, as well as their location was recorded for each tooth.

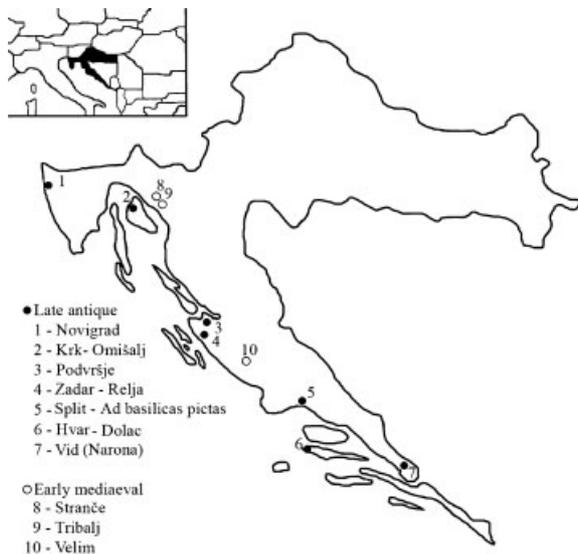


Figure 1. Map of Croatia with the geographical positions of the analysed sites. Full circles indicate Late antique, empty circles Early mediaeval sites.

A tooth was scored as lost ante mortem if the tooth socket showed any sign of alveolar bone resorption (Ortner & Putschar, 1981). If there was no evidence of remodelling, the tooth was considered to be lost post mortem. At this point it must be noted that unlike the other pathologies analysed in this study—where frequencies are based on the number of teeth or alveoli present, frequencies for ante mortem tooth loss are calculated based on the number of ante mortem absent teeth (per tooth socket available for examination).

Abscesses were diagnosed by the presence of a perforating fistula in which the internal zone of the bone (the site of the inflammation), and the buccal surface communicate by a canaliform connection (Brothwell, 1981). As this is a macroscopic analysis that does not evaluate the potential presence of small cavities in the periapical region, this study shows only cases resulting from acute or chronic abscesses (Alt *et al.*, 1998).

Calculus was broken down into three levels (slight, moderate and severe) according to the criteria of Brothwell (1981).

A tooth was considered positive for alveolar resorption if at least a 2 mm distance was observed between the cement enamel junction of the tooth and the alveolar bone crest (Clarke *et al.*, 1986).

Degree of dental wear was recorded according to Smith (Smith, 1984). Smith's method uses an eight-stage system to describe degree of wear on all teeth. For the purpose of this analysis teeth were additionally grouped as posterior (molars and premolars) and anterior teeth (canines and incisors). The degrees of dental wear were grouped as mild (Smith degrees 1 and 2), intermediate (degrees 3 and 4) and heavy (degrees 5–8). In this study we present only the results for heavy wear. Teeth in which the occlusal surface was destroyed by large carious lesions were excluded from the analysis.

Frequencies were calculated for each type of lesion recorded, and statistical comparisons by age and sex were performed using the χ^2 test employing Yates correction when appropriate. All statistical analyses were performed using the SPSS statistical package, version 14.0.

Results

The Late Antique series consist of 49 males and 54 females yielding a male/female ratio of 1:1.1 (Table 1). The Early Medieval series consist of 87 males and 64 females giving a male/female ratio of 1:0.74. Both samples are biased towards older age categories. The percentage of individuals older than 36 years in the Late

Antique series is 58.2%, in the Early Medieval series 64.2%.

Of the 4699 permanent teeth examined in this study, 1992 (42.4%) were from the Late Antique sample and 2707 (57.6%) were from the Early Medieval sample. The Late Antique sample comprised of 1046 female teeth and 946 male teeth. In the Early Medieval sample 1590 teeth are from males and 1117 from females.

Dental caries

Caries frequencies (Table 2) in the Late Antique series are higher in males (104/946 or 10.9%) than in females (89/1046 or 8.5%) but the difference is not significant ($\chi^2 = 3.227$, $p = 0.072$). Both males and females in the Late Antique sample exhibit higher caries frequencies in the older age category. This general trend, however, obscures important sex differences. Older males in the Late Antique series exhibit a significantly higher frequency of caries than younger males (14.9% compared to 5.0%; $\chi^2 = 21.706$, $p < 0.0001$), while in females the frequency of carious lesions in younger (7.6%) and older (9.5%) individuals is not significantly different ($\chi^2 = 1.021$, $p = 0.312$). At the level of the total Late Antique sample, however, the frequency of carious lesions is significantly higher in older individuals ($\chi^2 = 18.861$, $p < 0.0001$).

In the Early Medieval series caries frequencies are higher in females (12.6%) than males (11.1%) but the difference is not significant ($\chi^2 = 1.266$, $p = 0.260$). In the male subsample caries frequencies are significantly higher in the older age category (13.3% compared to 8.1%; $\chi^2 = 9.964$, $p = 0.001$), while in females these frequencies are almost identical (12.8% compared to 12.5%). Once again, however, at the level of the total Early Medieval sample the frequency of carious lesions is significantly higher in older individuals ($\chi^2 = 5.299$, $p = 0.021$).

Comparisons between the series (Table 3) indicate significantly higher caries frequencies in the Early Medieval series at the level of complete samples (193/1992 or 9.7% in the Late Antique series compared to 318/2707 or 11.1% in the Early Medieval series; $\chi^2 = 4.807$, $p = 0.002$), as well as in the younger age category (61/930 or 6.6% compared to 127/1249 or 10.2%; $\chi^2 = 8.356$, $p = 0.003$).

Analyses that control for sex show that these differences are primarily the result of significantly higher females caries frequencies in the Early Medieval period—both at the level of the complete female subsample (89/1046 or 8.5% in the Late Antique series

Table 2. Frequencies of dental and periodontal pathologies in the Late Antique and Early Medieval series by age and sex

| Age | Late Antique | | | | | | Early Medieval | | | | | |
|---------------------|--------------|------|----------|------|-----------|------|----------------|------|----------|------|-----------|------|
| | Males | % | Females | % | Total | % | Males | % | Females | % | Total | % |
| Dental caries | | | | | | | | | | | | |
| ≤35 | 19/377 | 5.0 | 42/553 | 7.6 | 61/930 | 6.6 | 54/665 | 8.1 | 73/584 | 12.5 | 127/1249 | 10.2 |
| 36+ | 85/569 | 14.9 | 47/493 | 9.5 | 132/1062 | 12.4 | 123/925 | 13.3 | 68/533 | 12.8 | 191/1458 | 13.1 |
| Total | 104/946 | 10.9 | 89/1046 | 8.5 | 193/1992 | 9.7 | 177/1590 | 11.1 | 141/1117 | 12.6 | 318/2707 | 11.7 |
| AMTL | | | | | | | | | | | | |
| ≤35 | 21/398 | 5.3 | 27/590 | 4.6 | 48/988 | 4.9 | 43/778 | 5.5 | 80/693 | 11.5 | 123/1471 | 8.4 |
| 36+ | 122/752 | 16.2 | 118/642 | 18.4 | 240/1394 | 17.2 | 387/1464 | 26.4 | 317/879 | 36.1 | 704/2343 | 30.0 |
| Total | 143/1150 | 12.4 | 145/1232 | 11.8 | 288/2382 | 12.1 | 430/2242 | 19.2 | 397/1572 | 25.3 | 827/3814 | 21.7 |
| Abscesses | | | | | | | | | | | | |
| ≤35 | 4/398 | 1.0 | 7/590 | 1.2 | 11/988 | 1.1 | 22/778 | 2.8 | 22/693 | 3.2 | 44/1471 | 2.9 |
| 36+ | 24/752 | 3.2 | 20/642 | 3.1 | 44/1394 | 3.2 | 97/1464 | 6.6 | 55/879 | 6.3 | 152/2343 | 6.5 |
| Total | 28/1150 | 2.4 | 27/1232 | 2.2 | 55/2382 | 2.3 | 119/2242 | 5.3 | 77/1572 | 4.9 | 196/3814 | 5.1 |
| Calculus | | | | | | | | | | | | |
| ≤35 | 289/377 | 76.7 | 332/508 | 65.3 | 621/885 | 70.2 | 327/566 | 57.8 | 324/525 | 61.7 | 651/1091 | 59.7 |
| 36+ | 294/361 | 81.4 | 388/453 | 85.6 | 682/814 | 83.8 | 616/845 | 72.9 | 351/512 | 68.5 | 967/1357 | 71.3 |
| Total | 583/738 | 79.0 | 720/961 | 74.9 | 1303/1699 | 76.7 | 943/1411 | 66.8 | 675/1037 | 65.1 | 1618/2448 | 66.1 |
| Alveolar resorption | | | | | | | | | | | | |
| ≤35 | 115/234 | 49.1 | 110/247 | 44.5 | 225/481 | 46.8 | 177/277 | 63.9 | 142/272 | 52.2 | 319/549 | 58.1 |
| 36+ | 132/159 | 83.0 | 167/219 | 76.2 | 299/378 | 79.1 | 255/308 | 82.8 | 140/166 | 84.3 | 395/474 | 83.3 |
| Total | 247/393 | 62.8 | 277/466 | 59.4 | 524/859 | 61.0 | 432/585 | 73.8 | 282/438 | 64.4 | 714/1023 | 69.8 |

compared to 141/1117 or 12.6% in the Early Medieval series; $\chi^2 = 9.195$, $p = 0.001$, and for young females (42/553 or 7.6% compared to 73/584 or 12.5%; $\chi^2 = 6.987$, $p = 0.006$). No differences were noted in the male sub samples.

AMTL

AMTL frequencies (Table 2) in the Late Antique series are higher in males (143/1150 or 12.4%) than in females (145/1232 or 11.8%) but, similarly to the trend noted in

Table 3. Comparisons of occurrence of dental features in the analysed series

| Dental feature | LA vs. EM males | | | LA vs. EM females | | | LA vs. EM total | | |
|---------------------|-----------------|----------|---------------------|-------------------|----------|---------------------|-----------------|----------|---------------------|
| | N | χ^2 | p | N | χ^2 | p | N | χ^2 | p |
| Dental caries | | | | | | | | | |
| ≤35 | 1042 | 3.048 | 0.061 | 1137 | 6.987 | 0.006 ^a | 2179 | 8.356 | 0.003 ^a |
| 36+ | 1494 | 0.661 | 0.373 | 1026 | 2.361 | 0.102 | 3582 | 0.191 | 0.619 |
| Total | 2537 | 0.002 | 0.913 | 2163 | 9.195 | 0.001 ^a | 4699 | 4.807 | 0.002 ^a |
| AMTL | | | | | | | | | |
| ≤35 | 1176 | 0.002 | 0.858 | 1283 | 19.338 | 0.000 ^a | 2459 | 10.676 | 0.0008 ^a |
| 36+ | 2216 | 28.702 | <0.001 ^a | 1521 | 55.954 | <0.001 ^a | 3737 | 75.528 | <0.001 ^a |
| Total | 3392 | 24.151 | <0.001 ^a | 2804 | 79.685 | <0.001 ^a | 6196 | 90.78 | <0.001 ^a |
| Abscesses | | | | | | | | | |
| ≤35 | 1176 | 3.247 | 0.044 ^a | 1283 | 4.873 | 0.016 ^a | 2459 | 8.691 | 0.002 ^a |
| 36+ | 2216 | 10.695 | 0.001 ^a | 1521 | 7.157 | 0.005 ^a | 3737 | 18.849 | 0.0000 ^a |
| Total | 3392 | 14.448 | <0.001 ^a | 2804 | 13.42 | 0.001 ^a | 6196 | 29.488 | <0.001 ^a |
| Calculus | | | | | | | | | |
| ≤35 | 943 | 34.794 | <0.001 ^b | 1033 | 1.323 | 0.250 | 1976 | 23.031 | <0.001 ^b |
| 36+ | 1206 | 9.507 | 0.002 ^b | 965 | 38.223 | <0.001 ^b | 2171 | 43.012 | <0.001 ^b |
| Total | 2149 | 34.246 | <0.001 ^b | 1998 | 22.409 | <0.001 ^b | 4147 | 53.582 | <0.001 ^b |
| Alveolar resorption | | | | | | | | | |
| ≤35 | 511 | 10.679 | 0.001 ^a | 519 | 2.750 | 0.097 | 1030 | 12.751 | <0.001 ^a |
| 36+ | 467 | 0.000 | 1.000 | 385 | 3.333 | 0.067 | 852 | 2.221 | 0.136 |
| Total | 978 | 12.878 | <0.001 ^a | 904 | 2.131 | 0.144 | 1882 | 15.652 | <0.001 ^a |

^aDifferences between the LA and EM series are the result of significantly higher frequencies in the EM period.

^bDifferences between the LA and EM series are the result of significantly higher frequencies in the LA period.

caries frequencies, the difference is not significant ($\chi^2 = 0.189$, $p = 0.663$). Both males and females in the Late Antique sample exhibit significantly higher AMTL frequencies in the older age category ($\chi^2 = 27.647$, $p < 0.0001$ for males, and $\chi^2 = 55.094$, $p < 0.0001$ for females).

In the Early Medieval series AMTL frequencies are, at the level of the complete sample, significantly higher in females (397/1572 or 25.3%) than in males (430/2242 or 19.2%; $\chi^2 = 19.727$, $p < 0.0001$). The same trend is present in the young adult ($\chi^2 = 16.541$, $p < 0.0001$), and old adult ($\chi^2 = 23.773$, $p < 0.0001$) age categories. In both sexes AMTL frequencies are significantly higher in older age categories: 26.4% compared to 5.5%; $\chi^2 = 141.916$, $p < 0.0001$ in males, and 36.1% compared to 11.5%; $\chi^2 = 122.122$, $p < 0.0001$ in females.

Comparisons between the Late Antique and Early Medieval series (Table 3) show significantly higher frequencies of AMTL in the Early Medieval series in all age and sex categories except for young males.

Abscesses

Abscesses frequencies (Table 2) in the Late Antique series are similar in both sexes (28/1150 or 2.4% for males compared to 27/1232 or 2.2% for females). In both sexes frequencies are also significantly higher in the older age categories (for males: $\chi^2 = 4.357$, $p = 0.037$; for females $\chi^2 = 4.474$, $p = 0.034$).

Male (119/2242 or 5.3%) and female (77/1572 or 4.9%) abscess frequencies are also similar in the Early Medieval series. In both sexes, differences between abscess frequencies are, once again, significantly higher in the older age category (for males $\chi^2 = 13.834$, $p = 0.0001$; for females $\chi^2 = 7.256$, $p = 0.007$).

Comparisons between the series (Table 3) show significantly higher frequencies of abscesses in all age and sex categories in the Early Medieval series.

Calculus

In the Late Antique series males exhibit (Table 2) a marginally not significantly higher rate of calculus than

females (583/738 or 79.0% compared to 720/961 or 74.9%; $\chi^2 = 3.657$, $p = 0.055$). This difference is primarily caused by the significantly higher calculus rates that young males have in comparison to young females (76.7% compared to 65.3%; $\chi^2 = 12.677$, $p = 0.0004$). Male/female differences are not significant in the older adult subsample (81.4% compared to 85.6%; $\chi^2 = 2.321$, $p = 0.128$). Both sexes exhibit higher calculus rates in the older age category but the difference is significant only in females (65.3% compared to 85.6%; $\chi^2 = 51.431$, $p < 0.0001$). At the level of the complete Late Antique sample the difference is, however, significant (83.8% compared to 70.2%; $\chi^2 = 43.207$, $p < 0.001$).

In the Early Medieval series the rates of calculus are similar in males and females (943/1411 or 66.8% compared to 675/10371 or 65.1%; $\chi^2 = 0.735$, $p = 0.392$). Both sexes exhibit significantly higher calculus rates in the older age category—in males 72.9% compared to 57.8% ($\chi^2 = 34.305$, $p < 0.0001$), in females 68.5% compared to 61.7% ($\chi^2 = 5.043$, $p = 0.025$).

Comparisons between the Late Antique and Early Medieval series (Table 3) show significantly higher calculus rates in the Late Antique series in all age and sex categories except for young females.

Similarly, when calculus is analysed by severity (Table 4) calculus levels 1 and 2 are significantly higher in the Late Antique series (for calculus level 1 $\chi^2 = 20.853$, $p < 0.0001$; for calculus level 2 $\chi^2 = 18.4770$, $p < 0.0001$). Calculus level 3 is, however, significantly higher in the Early Medieval series ($\chi^2 = 5.069$, $p = 0.024$).

Alveolar resorption

Alveolar resorption frequencies (Table 2) in the Late Antique series are similar in both sexes (247/393 or 62.8% for males compared to 277/466 or 59.4% for females; $\chi^2 = 0.902$, $p = 0.342$). In both sexes frequencies are also significantly higher in the older age categories (for males: $\chi^2 = 45.084$, $p < 0.0001$; for females $\chi^2 = 47.142$, $p < 0.0001$).

Table 4. Calculus by severity in the Late Antique and Early Medieval series

| Series | N of teeth affected | | | | Calculus rates (%) | | | | |
|--------------|---------------------|-----|----|------|--------------------|------|-----|-------|--------------------|
| | 1 ^a | 2 | 3 | Sum | 1 | 2 | 3 | Total | Total ^b |
| Late Antique | 1081 | 215 | 7 | 1303 | 63.6 | 12.6 | 0.4 | 76.7 | 1699 |
| Early Med. | 1383 | 208 | 27 | 1618 | 56.5 | 8.5 | 1.1 | 66.1 | 2448 |

^a Calculus levels 1–3 according to Brothwell (1981); 1 = slight; 2 = moderate; 3 = severe.

^b Total number of teeth examined.

In the Early Medieval series males exhibit significantly higher rates of alveolar resorption than females (432/585 or 73.8% compared to 282/438 or 64.4%; $\chi^2 = 10.194$, $p = 0.001$). This difference is primarily caused by the significantly higher rates of alveolar resorption that young males have in comparison to young females (63.9% compared to 52.2%; $\chi^2 = 7.235$, $p = 0.007$). Male/female differences are not significant in the older adult subsample ($\chi^2 = 0.090$, $p = 0.763$). In both sexes frequencies are also significantly higher in the older age categories (for males: $\chi^2 = 25.984$, $p < 0.0001$; for females $\chi^2 = 45.022$, $p < 0.0001$).

Comparisons between the series (Table 3) indicate significantly higher alveolar resorption rates in the Early Medieval series at the level of complete samples (524/859 or 61.0% in the Late Antique series compared to 714/1023 or 69.81% in the Early Medieval series; $\chi^2 = 15.652$, $p < 0.0001$), as well as in the younger age category (225/481 or 46.8% compared to 319/549 or 58.1%; $\chi^2 = 12.751$, $p < 0.001$).

Analyses that control for sex suggest that this is primarily caused by the significantly higher frequencies of alveolar resorption that young males in the Early Medieval period have in comparison to young males from the Late Antique series (63.9% compared to 49.1%; $\chi^2 = 10.679$, $p = 0.001$). No differences were noted in the female subsample.

Wear

Of the 1992 permanent teeth from the Late Antique sample, 1951 teeth with preserved occlusal surfaces

(97.9% of the total sample) were examined for the presence of heavy wear. In the Early Medieval sample 2658/2707 (98.2% of the total sample) had sufficiently preserved occlusal surfaces.

At the level of complete samples (Table 5), the frequencies of heavy wear in the Late Antique and Early Medieval series are very similar: 739/1951 or 37.9% of teeth in the Late Antique series exhibit wear equivalent to, or greater than Smith stage 5, compared to 1006/2628 or 38.3% of teeth in the Early Medieval series ($\chi^2 = 0.061$, $p = 0.805$). In both samples males exhibit significantly higher wear than females. In the Late Antique series males have a 42.0% (387/922) frequency of heavy wear compared to 34.2% (352/1029) in females ($\chi^2 = 12.136$, $p = 0.005$), in the Early Medieval series males have a 42.7% (671/1571) frequency of heavy wear compared to 31.7% (335/10579) in females ($\chi^2 = 32.003$, $p < 0.001$). Differences between the series at the level of male ($\chi^2 = 0.101$, $p = 0.750$) and female ($\chi^2 = 1.381$, $p = 0.240$) subsamples are not significant. In both series heavy wear frequencies are significantly higher in the older age categories (for Late Antique males: $\chi^2 = 99.999$, $p < 0.0001$; for Late Antique females $\chi^2 = 229.235$, $p < 0.0001$; for Early Medieval males: $\chi^2 = 163.419$, $p < 0.0001$; for Early Medieval females $\chi^2 = 34.542$, $p < 0.0001$).

When, however, heavy wear is analysed by mandible and maxilla, as well as by posterior and anterior teeth (Table 6) significant differences between the series are revealed. A total of 15 significant differences are noted—three when heavy wear is analysed based on the location of the tooth in the upper or lower jaw, and 12 when the teeth were divided into anterior and posterior groups.

Table 5. Frequency of heavy tooth wear (Smith's stages 5–8) by age and sex

| Age | Late Antique | | | | | | Early Medieval | | | | | |
|------------------------|--------------|------|---------|------|----------|------|----------------|------|---------|------|----------|------|
| | Males | % | Females | % | Total | % | Males | % | Females | % | Total | % |
| Maxilla | | | | | | | | | | | | |
| 18–35 | 33/181 | 18.2 | 35/229 | 15.3 | 68/410 | 16.6 | 59/310 | 19.0 | 46/283 | 16.2 | 105/593 | 17.7 |
| 36+ | 136/240 | 56.7 | 136/211 | 64.4 | 272/451 | 60.3 | 258/404 | 63.9 | 98/216 | 45.4 | 356/620 | 57.4 |
| Total | 169/421 | 40.1 | 171/440 | 38.9 | 340/861 | 39.5 | 317/714 | 44.4 | 144/499 | 28.8 | 461/1213 | 38.0 |
| Mandible | | | | | | | | | | | | |
| 18–35 | 39/192 | 20.3 | 37/319 | 11.6 | 76/511 | 14.9 | 54/350 | 15.4 | 59/270 | 21.8 | 113/620 | 18.2 |
| 36+ | 179/309 | 57.9 | 144/270 | 53.3 | 323/579 | 55.8 | 300/507 | 59.2 | 132/288 | 45.8 | 432/795 | 54.3 |
| Total | 218/501 | 43.5 | 181/589 | 30.7 | 399/1090 | 36.6 | 354/857 | 41.3 | 191/558 | 34.2 | 545/1415 | 38.5 |
| Anterior teeth | | | | | | | | | | | | |
| 18–35 | 55/142 | 38.7 | 48/197 | 24.4 | 103/339 | 30.4 | 55/227 | 24.2 | 65/226 | 28.8 | 120/453 | 26.5 |
| 36+ | 180/224 | 80.4 | 133/194 | 68.6 | 313/418 | 74.9 | 277/375 | 73.9 | 124/218 | 56.9 | 401/593 | 67.6 |
| Total | 235/366 | 64.2 | 181/391 | 46.3 | 416/757 | 55.0 | 332/602 | 55.1 | 189/444 | 42.6 | 521/1046 | 49.8 |
| Posterior teeth | | | | | | | | | | | | |
| 18–35 | 17/231 | 7.4 | 24/351 | 6.8 | 41/582 | 7.0 | 58/433 | 13.4 | 40/327 | 12.2 | 98/760 | 12.9 |
| 36+ | 135/325 | 41.5 | 147/287 | 51.2 | 282/612 | 46.1 | 281/536 | 52.4 | 106/286 | 37.1 | 387/822 | 47.1 |
| Total | 152/556 | 27.3 | 171/638 | 26.8 | 323/1194 | 27.1 | 339/969 | 35.0 | 146/613 | 23.8 | 485/1582 | 30.7 |

Table 6. Comparisons of occurrence of tooth wear in the analysed series

| Tooth wear | Late Antique vs. Early Medieval males | | | Late Antique vs. Early Medieval females | | | Late Antique vs. Early Medieval total | | |
|-----------------|---------------------------------------|----------|--------------------|---|----------|---------------------|---------------------------------------|----------|---------------------|
| | <i>N</i> | χ^2 | <i>p</i> | <i>N</i> | χ^2 | <i>p</i> | <i>N</i> | χ^2 | <i>p</i> |
| Maxilla | | | | | | | | | |
| 18–35 | 491 | 0.01 | 0.920 | 512 | 0.03 | 0.860 | 1003 | 0.14 | 0.706 |
| 36+ | 644 | 2.98 | 0.083 | 427 | 14.93 | 0.0001 ^a | 1071 | 0.78 | 0.375 |
| Total | 1135 | 1.78 | 0.181 | 939 | 10.05 | 0.001 ^a | 2074 | 0.40 | 0.523 |
| Mandible | | | | | | | | | |
| 18–35 | 542 | 1.75 | 0.185 | 589 | 10.52 | 0.001 ^b | 1131 | 2.02 | 0.154 |
| 36+ | 816 | 0.07 | 0.782 | 558 | 2.84 | 0.091 | 1374 | 0.22 | 0.633 |
| Total | 1358 | 0.54 | 0.460 | 1147 | 1.44 | 0.229 | 2505 | 0.87 | 0.349 |
| Anterior teeth | | | | | | | | | |
| 18–35 | 369 | 8.10 | 0.004 ^a | 427 | 0.82 | 0.363 | 792 | 1.26 | 0.260 |
| 36+ | 599 | 2.91 | 0.087 | 412 | 5.47 | 0.01 ^a | 1011 | 5.88 | 0.015 ^a |
| Total | 968 | 7.32 | 0.006 ^a | 839 | 1.02 | 0.312 | 1803 | 4.45 | 0.034 ^a |
| Posterior teeth | | | | | | | | | |
| 18–35 | 664 | 4.89 | 0.026 ^b | 678 | 5.15 | 0.023 ^b | 1342 | 11.52 | 0.0006 ^b |
| 36+ | 861 | 9.17 | 0.002 ^b | 573 | 11.07 | 0.0008 ^a | 1434 | 0.10 | 0.747 |
| Total | 1525 | 9.11 | 0.002 ^b | 1251 | 1.39 | 0.237 | 2776 | 4.11 | 0.042 ^b |

^a Differences between the LA and EM series are the result of significantly higher frequencies in the LA period.

^b Differences between the LA and EM series are the result of significantly higher frequencies in the EM period.

Higher frequencies of heavy wear were recorded in the Early Medieval series in seven cases, while in eight cases higher frequencies were recorded in the Late Antique series.

Analyses that divide the teeth by upper and lower jaw show no clear pattern. All differences were noted in females with older and total female heavy wear in the maxillary teeth being higher in the Late Antique series, and younger female heavy wear in the mandible higher in the Early Medieval series.

In contrast to this, analyses that control for the anterior or posterior position of the teeth in the dentition show a uniform pattern. Differences noted in the posterior teeth tend to be (in 6/7 cases) caused by significantly higher wear in the Early Medieval series. Three differences are noted in the male subsample, one in the female, and two are at the level of complete samples including among them, importantly, total heavy wear in all posterior teeth. Differences noted in the anterior teeth (in all five cases) were the result of higher wear in the Late Antique series. Two differences are noted in the male subsample, one in the female and two are at the level of complete samples including among them again, importantly, total heavy wear in all anterior teeth.

Discussion

As previously noted, historical sources for the Late Antique/Early Medieval transition in Croatia are

remarkably rare. Early Croats did not leave written records, and the available scarce Byzantine and Frankish records that deal with the Croats focus primarily on their military and political characteristics. Early Croat culture, subsistence strategies, knowledge of medicine and everyday life were of little interest to these authors and thus remain unknown to us (Budak, 1994; Goldstein, 1995).

In contrast to this, data pertaining to the everyday life and thus the dietary habits and nutrition of Late Antique populations are available in the writings of numerous antique authors including *Cato* (234 BC–149 BC), *Silius Italicus* (25 AD–101 AD) and *Pliny* (61 AD–113 AD) (as reported in White, 1970; Dosi & Schnell, 1990). While these data primarily describe the dietary habits and nutrition of populations that inhabited central and southern Italy, two reasons suggest that they are applicable to the Late Antique populations that inhabited Croatia's eastern Adriatic coast. The first is that the ecological features of the eastern Adriatic coast are similar to those of central and southern Italy—both have a Mediterranean climate, and the populations inhabiting them based their subsistence strategies on the cultivation of olives, grapes, fishing and transhumance goat and sheep herding. The second is the marked cultural uniformity in dietary habits, nutrition and health practices that characterised the entire Roman Empire and expressed itself through such features as the enthusiastic spread of viticulture in all parts of the Roman Empire, the considerable effort that was put into the draining of marshes and swamps, and

the emphasis that was placed on the availability of fresh drinking water and waste disposal in urban centres.

According to the available historical sources the typical meal of the lower and middle classes in Roman Italy consisted of bread (rich in bran and impurities), porridge of cereals (*puls*), wine, vegetables, some fruit and olives (Dosi & Schnell, 1990). The main staples of everyday diet included wheat, olives, wine and figs. Periodical fishing, as well as transhumance goat and sheep herding, also contributed to the dietary resource pool. With one provision there seems little doubt that the same foodstuffs dominated the nutrition of the Late Antique populations that inhabited Dalmatia. The provision applicable to the Croatian sample concerns the fact that all of the Late Antique osteological material derives from maritime urban communities, some of which—particularly Zadar-Relja, Vid (Narona) and Split-Ad basilicas pictas, were large centres for commercial activities and fishing. The social composition of the osteological sample reflects this and the recovered archaeological artefacts and available epigraphic data suggest that most skeletons belonged to middle or upper class individuals engaged in various commercial activities (Oreb *et al.*, 1999; Mardešić, 2004).

Comparisons between the Late Antique and Early Medieval series in Croatia show a general trend of deteriorating dental health. Significant increases, at the level of complete samples, are recorded for the frequencies of caries, abscesses, AMTL and alveolar resorption in the Early Medieval series. In addition, heavy wear on the posterior teeth is significantly higher in the Early Medieval series.

The higher frequency of heavy wear on the posterior teeth of the Early Medieval sample suggests a diet with more abrasive, hard, fibrous foods requiring vigorous mastication. It is also, however, possible that differential food preparing techniques—particularly those related to the preparation of vegetables (Bonfiglioli *et al.*, 2003) were responsible for this difference. Dental wear rates are multifactorial and depend on numerous factors including the consistency and texture of food, but also food preparation techniques, age and sex (Hillson, 1979; Walker *et al.*, 1991).

The Late Antique series exhibits significantly higher rates of heavy wear on the anterior dentition which raises the possibility that non-dietary factors, possibly activities related to fishing (making fishing nets) may have contributed to the wearing down of their front teeth. Of potential interest in this context is the fact that males in the Late Antique series consistently—in both age categories, and at the level of complete samples, exhibit significantly higher rates of anterior

wear than females ($\chi^2 = 23.794$, $p < 0.001$, for the complete sample), and that significant differences in wear rates between the Late Antique and Early Medieval series are present only in the male subsamples.

An alternative explanation is that because of severe AMTL in the posterior dentition—in the Late Antique series AMTL is considerably more prevalent in the posterior (246/288 or 85.4%) than the anterior (42/288 or 14.6%) dentition, the canines and incisors took on the function of the molars (Højgaard, 1981). Given that the composite Early Medieval Croatian sample also exhibits consistently higher rates of heavy wear in the anterior dentition—and similarly has considerably more AMTL in the posterior dentition (658/827 or 79.6% compared to 169/827 or 20.4%), this interpretation seems more likely.

At the level of complete samples caries frequencies are significantly higher in the Early Medieval series. This general trend, however, obscures an important sex difference. While female caries rates are significantly higher in the early Medieval series (both at the level of complete samples, and in the younger age category), male frequencies are very similar (10.9% in the Late Antique compare to 11.1% in the Early Medieval series at the level of complete samples).

Most analyses of dental pathologies report a correlation between caries rates and diet. High caries rates are correlated with a greater consumption of carbohydrates, while low rates of caries are correlated with low carbohydrate diets. The reason for this is that micro-organisms in the bacterial plaque metabolise carbohydrates, thus lowering the pH of the oral cavity, and favouring the destruction of the hard tissues of the tooth (Powel, 1985). High levels of proteins and fat in the diet are, on the other hand, thought to inhibit caries. Other factors that affect the rates of caries are mouth acidity (alkaline), and fluoride levels in the water (Molnar & Molnar, 1985). At a global level, it is commonly accepted that with the onset of agriculture, a diet rich in carbohydrates was introduced resulting in a dramatic increase in caries rates (Hillson, 1979; Turner, 1979; Larsen, 1981; Larsen *et al.*, 1991).

The significantly different caries rates between the Late Antique and Early Medieval series suggest markedly different alimentary habits, and a significant increase in carbohydrates in the Early Medieval diet. This is consistent with the meagre historical sources that report on the alimentary habits of Early Medieval populations in Europe. According to these sources individuals belonging to lower socio-economic classes had a diet essentially based on cereals (bread represented 70% of the food intake), while the intake

of proteins (in the form of fresh meat and fish) was low and infrequent (Cortonesi, 1981; Mazzi, 1981).

The significant increase in total and female caries rates in the Early Medieval period, combined with the absence of this trend in males is intriguing. As there are no significant sex differences in caries frequencies in either series, it seems reasonable to assume that males and females were consuming foods with similar cariogenic properties during both the Late Antique and Early Medieval period. A possible explanation why the hypothesised increase of carbohydrates in the Early Medieval diet did not adversely affect male dentitions lies in the following.

In both series carious lesions are more frequent in the posterior dentition (168/193 or 87.0% compared to 25/193 or 13.0% for the anterior teeth in the Late Antique series, and 277/318 or 87.9% compared to 41/318 or 13.0% in the Early Medieval series). This can be explained by the fact that bacterial plaque accumulates more easily on surfaces with pits and cracks, and is also less easily removed from these surfaces by saliva flow and the actions of the tongue and cheeks (Powel, 1985). In the last couple of decades some authors have reported a negative correlation between heavy wear and caries frequencies caused by the cancellation of the sulci and fossae that are the natural morphology of the tooth, and by the removal of carious tissue (Maat & Van der Velde, 1987; Kerr *et al.*, 1990; Hillson, 2001). Applying this information to the Croatian samples it becomes apparent that unlike the situation in females—where total rates of posterior wear are similar in the Late Antique and Early Medieval series, the posterior teeth of Early Medieval males exhibit significantly more heavy wear (in both age categories, and at the level of complete samples) than those of Late Antique males. It is, therefore, possible that some caries were removed by heavy wear resulting in similar caries rates between males despite an increase of carbohydrates in the Early Medieval diet.

Significantly higher abscess frequencies are recorded in all age and sex categories in the Early Medieval series. This is consistent with the total higher caries rates, and the higher male heavy wear rates in posterior teeth recorded in this series. The most common aetiologic factors of abscesses in archaeological populations are penetrating and destructive caries with pulp cavity exposure, heavy wear and trauma (Littleton & Frohlich, 1993; Dias & Tayles, 1997). It would appear that in this data set the higher caries rates in females and higher male heavy wear rates in posterior teeth were responsible for the significant increase in abscess frequencies during the Early Medieval period. In both series abscesses are significantly more frequent in the

older age category reflecting the progressive deterioration of the tooth; caries may appear at a young age but need time to invade the pulp cavity and cause an abscess (Beckett & Lovell, 1994). Similarly, time is required if heavy wear is to result in pulp exposure and the onset of abscesses (Scott & Turner, 1988). At this point it is relevant to, once again, note that as only macroscopic diagnosis was employed in this study the figures reported for abscess frequencies in both series are underestimated.

Except for young males, AMTL frequencies are significantly higher in all age and sex categories in the Early Medieval series. Determining the causes of AMTL in archaeological populations is difficult. The causes include: caries, abscesses, heavy wear, calculus, alveolar resorption and trauma (Hillson, 2000). Metabolic diseases such as scurvy can also lead to AMTL (Ortner & Putschar, 1981). The fact that in both samples dental caries and AMTL most frequently affects the posterior dentition suggests that caries may have been a major cause of tooth loss in both series. Higher rates of AMTL in older males from the Early Medieval series may have also been caused by the considerable masticatory stress their posterior teeth were exposed to as revealed by the significantly higher rates of heavy wear that they exhibit on these teeth. This masticatory stress may have destabilised the tooth thus increasing its mobility and the likelihood of its loss (Belcastro *et al.*, 2007). Of interest is the fact that in this data set calculus did not contribute significantly to AMTL.

In contrast to the trend noted in caries, abscess and AMTL frequencies, calculus is significantly more prevalent in the Late Antique series. Calculus formation is related to both diet and non-dietary factors (Hillson, 2001). Among the non-dietary factors linked to its formation are: poor oral hygiene, the mineral content of drinking water, rate of salivary flow, culturally derived patterns of behaviour and teeth utilised as tools (Lieverse, 1999). The association between diet and calculus is not straightforward and high calculus rates have been recorded in both high carbohydrate, and high protein diets (Meiklejohn & Zvelebil, 1991; Lieverse, 1999; Lillie & Richards, 2000). In combination with caries rates, however, calculus has been used to assess the relative contribution of carbohydrates versus proteins to the diet. High calculus rates combined with low caries rates are characteristic of populations subsiding on high protein/low carbohydrate diets while high calculus rates combined with high caries rates are characteristic of populations subsiding on high carbohydrate/low protein diets (White, 1994; Lillie, 1996).

In this context, the characteristics of the Late Antique series—a combination of lower caries with higher calculus rates indicating a relatively high protein diet—are consistent with the available archaeological and historical data that suggest most of the individuals from this series were from the middle or upper classes. Comparison between the series (lower caries and higher calculus rates in the Late Antique series compared to higher caries and lower calculus rates in the Early Medieval series) are also consistent with the hypothesised change from a diet with relatively more protein in the Late Antique period, to one with less protein in the Early Medieval period.

The same principle has been utilised to assess potential sex differences reflecting unequal access to dietary protein (Lillie & Richards, 2000). In this context, the absence of significant differences between males and females in both series suggests they consumed a similar diet.

At the level of total samples calculus is, like abscesses and AMTL, significantly more common in older individuals in both series. This trend has been observed in other populations and reflects the progressive build-up of calculus with age (Beiswanger *et al.*, 1989).

At the level of both total samples, and younger adults, significantly higher frequencies of alveolar resorption are recorded in the Early Medieval series. These differences result primarily from significantly higher alveolar resorption frequencies recorded in the male subsample. The aetiology of alveolar resorption is multifactorial and includes dietary, hygienic, environmental and genetic components. In addition, Clarke *et al.* (1986) have noted differences between pre-modern and modern populations regarding the most common causes of alveolar resorption. According to their results, while the primary aetiologic factor of alveolar resorption in contemporary societies is bacterial plaque, whether mineralised (as dental calculus) or not, in archaeological populations factors such as heavy attrition (resulting from occlusal trauma), pulp damage, infection and mineral imbalance appear to be more important. As calculus rates are higher in the Late Antique than the Early Medieval series, it would appear that factors other than bacterial plaque contributed to the elevated rates of alveolar resorption during the Early Medieval period. Potential contributors include: systemic diseases such as scurvy, osteoporosis, diabetes and immunodeficiency diseases (Garcia *et al.*, 2001), generalised malnutrition (Enwonwu, 1995) and chronic occlusal trauma (Carranza, 2002). The significantly higher rate of heavy wear noted in the posterior dentition of the Early Medieval series suggests that chronic occlusal trauma

may have been a significant contributing factor. Trauma from occlusion can produce alveolar bone destruction in the absence or presence of inflammation. In the absence of inflammation changes caused by chronic occlusal trauma vary from increased compression of the periodontal ligament to necrosis of the periodontal ligament and bone with subsequent resorption of bone and tooth structure. When combined with inflammation, trauma from occlusion aggravates and increases bone destruction (Carranza, 2002). This is consistent with the hypothesised change to a diet with more abrasive, hard, fibrous foods requiring vigorous mastication—and hence greater occlusal trauma in the Early Medieval period. An additional factor that needs to be kept in mind is that extension of inflammation from the gingiva to the supporting periodontal tissues depends not only on the previously mentioned factors, but also on host resistance. Host resistance is determined by numerous factors including among them disease loads. In this context it is relevant to point out that, as previously noted, bioarchaeological analyses between a Late Antique and Early Medieval series from Croatia showed a significant increase in periostitis and cribra orbitalia frequencies suggesting an increase in parasite loads, and acute and chronic infectious diseases in males during the Early Medieval period in Dalmatia (Šlaus, 2008).

To put data on the dental health of the past inhabitants of Dalmatia during the Late Antique to Early Medieval transition into a broader geographical context, results from the Croatian series were compared to other Roman Imperial, and Middle Ages series from Italy (Manzi *et al.*, 1999; Cucina *et al.*, 2006; Belcastro *et al.*, 2007), France (Esclassan *et al.*, 2009), Austria (Meinl *et al.*, 2009) and England (Wells, 1982). The results, presented in Table 7, show a generalised worsening of dental health in all parts of the Western Roman Empire, suggesting a deterioration of living conditions with the transition to the Medieval period. The frequencies of caries and AMTL in both Croatian series are intermediate, while abscess and calculus frequencies are slightly higher than in the other series.

In summary, the results of our analyses show that the frequencies of carious lesions, AMTL, abscesses and alveolar resorption significantly increased during the Early Medieval period, as did the degree of heavy occlusal wear on posterior teeth. These data suggest a change in alimentary habits, with a significantly higher dependence on carbohydrates in the Early Medieval diet. The combination of higher calculus and lower caries rates in the Late Antique series similarly suggests more protein in the Late Antique diet and is, therefore, also consistent with the hypothesised change in alimentary habits.

Table 7. Comparisons between Croatian and other Late Antique and Early Medieval samples from Europe^a

| | Caries (%) | AMTL (%) | Abscesses (%) | Calculus (%) |
|--|------------|----------|---------------|--------------|
| Late antique sites | | | | |
| Isola Sacra, Italy 1–3 c. AD | 4.0 | 6.8 | 0.2 | 33.9 |
| Lucus Feroniae, Italy 2–4 c. AD | 6.1 | 12.4 | 0.6 | 26.9 |
| Quadrella, Italy 1–4 c. AD | 15.0 | 12.5 | 1.3 | 50.8 |
| Vallerano, Italy 2–3 c. AD | 2.5 | 3.4 | 1.1 | |
| Cirencester, England 3–5 c. AD | 5.1 | 8.5 | 1.2 | |
| Croatian sample, 3–6 c. AD (this study) | 9.7 | 12.1 | 2.3 | 76.7 |
| Early Medieval sites | | | | |
| La Selvicciola, Italy 7 c. AD | 12.6 | 18.2 | 0.8 | 27.1 |
| Vicenne-Campochiaro, Italy 6–8 c. AD | 15.1 | 13.5 | 4.5 | 60.6 |
| Vilarnau d'Amont, France 12–14 c. AD | 17.5 | 8.7 | | |
| Vienna, Austraia 6–8 c. AD | 14.9 | 23.8 | | |
| Croatian sample, 7–11 c. AD (this study) | 11.7 | 21.7 | 5.1 | 66.1 |

^aAll frequencies are per element (tooth/tooth socket).

In general (the two exceptions are male caries and female alveolar resorption frequencies) lesion frequencies increased uniformly in both sexes suggesting that the deterioration of dental health during the Early Medieval period equally affected males and females. The absence of a significant increase in male caries frequencies during the Early Medieval period may be a result of the significantly higher wear they exhibit on their posterior teeth and is therefore not inconsistent with an increase in carbohydrates in the Early Medieval diet. Similarly, female alveolar resorption frequencies increased during the Early Medieval period, almost achieving significance ($p=0.097$ for younger, and $p=0.067$ for older females) and are, therefore, also compatible with an increase in carbohydrates in the Early Medieval diet. As the same general trend of deteriorating health with the transition to the Early Medieval period in Dalmatia was observed when cribra orbitalia, linear enamel hypoplasia, non-specific periostitis and trauma frequencies were analysed (Šlaus, 2008) it would appear that the political, social, economic and religious changes that characterised the Late Antique/Early Medieval transition in Dalmatia resulted in a clear discontinuity, not only from the cultural, but also from the biological point of view with an evident deterioration of oral health during the Early Medieval period. Continued research of other Late Antique and Early Medieval skeletal series from Croatia are necessary to determine if data from these collections support the results of our analyses.

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