A 33-year-old man complained of a swelling of the gingiva in the right maxillary molar region. This swelling has occurred as a painless swelling of the buccal gingiva in that region for a period of five years. The swelling had increased and decreased repeatedly from its onset, however it was left untreated. Two weeks ago, he noticed increase of the swelling and was treated with incision for drainage. His doctor said that a translucent-brownish liquid had been observed in the lesion at the time of incision.

Oral examination revealed a bony hard swelling of the bucco-gingival sulcus in the region of the right upper second premolar-molar. The right maxillary tuberosity was
destroyed in the radiographic findings and it was tender to palpation. An elastic soft swelling $25 \times 20$mm in size, was located in the palatal aspect of the right maxillary second premolar-molar region. The overlying mucosa of the swelling appeared normal. The maxillary second molar was mobile and the maxillary second premolar was painful to percussion.

The panoramic radiograph showed bone destruction extending from the region of the right maxillary first molar posteriorly to the maxillary tuberosity of the same side and disappearance of the posterior and inferior walls of the right maxillary sinus (Fig. 1).

The Waters' view disclosed complete destruction of the lateral wall and increased radiopacity of the whole right maxillary sinus (Fig. 2).

On the frontal skull tomographs, a marked expansion of the lateral cortical plate of the right maxilla was noticed without any disruption of the thinning cortices (Fig. 3).

Computed tomographic (CT) scan with contrast enhancement displayed a cystic mass almost filling the right maxillary sinus, which was destroyed for the most part of the lateral and posterior walls by the solid components arising in the posterior portion of the lesion, additionally extending outwards into the adjacent soft tissues in the infratemporal fossa (Fig 4). Therefore, biopsy specimens were taken from the posterior portion that appeared as solid components on the CT image, and were immediately submitted to histologic examination leading to a diagnosis of ameloblastoma.

The patient was treated by partial maxillectomy. Further histologic examination of the resected materials led us to the final diagnosis of follicular type of ameloblastoma.

It is well-known that ameloblastomas are most commonly found in the mandible, and they are very rare in the maxilla. However, if it arises in the maxilla, it is more serious than in the mandible, because in the former it has a tendency of invading adjas-