A 66-year-old man presented with difficulty in breathing and swallowing caused by swelling in his throat. He was aware of this swelling for the last three years but he had avoided referring to a hospital until he started to have serious apnea attacks. Physical examination revealed a large mass in the oropharynx bulging submucosally from the right lateral pharyngeal wall that nearly occluded the whole oropharynx. The other remarkable findings were absence of the gag reflex on the right soft palate, deviation of the tongue to the right side and right vocal cord paralysis, reflecting glossopharyngeal, vagus and hypoglossal nerve palsies. On magnetic resonance imaging (MRI), a mass in the right parapharyngeal space was observed with the dimensions of 83x51x84 cm (anteroposterior x transverse x craniocaudal) obliterating nearly the whole parapharynx. The tumor had pushed the carotid space posteriorly and the masticator space anterolaterally. It had a heterogeneous hypointense signal but peripheral hyperintense signal due to hemorrhage on T1 weighted (T1W1) and heterogeneous hyperintense signal on T2W2. This mass lesion had also enlarged the stylomandibular foramen and had a solid component enhancing contrast intensely with a central large necrotic component (Figure 1a-c).

Following MRI of the mass a transoral fine needle aspiration (FNA) biopsy was performed, the result of which was non-diagnostic necrotic cells. The mass was surgically excised through a transcervical-transparotid approach.

**Diagnosis:** A giant benign mixed tumor (BMT) of the parapharyngeal space.

Benign mixed tumor is the most common benign tumor of the parapharyngeal space (PPS). They may originate from the deep lobe of the parotid or from parapharyngeally-located accessory minor salivary glands. The clinical picture of benign PPS tumors may be miscellaneous, and patients may present with a wide variety of symptoms and signs with the increase of the tumor size. Smaller tumors can remain as an asymptomatic mass displacing oropharyngeal structures medially, while in larger tumors the most common symptom is a neck mass. With the exception of direct invasion by malignancy or a neurogenic tumor, cranial nerve palsies are unusual for PPS tumors. Large PPS tumors can also burden the airway.

The differential diagnosis of a PPS mass is based on radiological and pathological findings. Either computed tomography (CT) or MRI reveal the boundaries of the mass and its relationship...