Figure 1. a. Lateral radiograph and **(b)** posterior-anterior radiograph of left ring finger shows no bony component to mallet injury.

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LEARNING POINTS

- The differential diagnosis for a mallet injury includes closed trauma, unnoticed closed injury, open tendon laceration, and spontaneous rupture secondary to rheumatoid arthritis or chronic haemodialysis.
- When the mechanism of injury is unclear, the spontaneous causes for mallet injury should be sought before the diagnosis of an unnoticed injury is made.
- Delay in prompt treatment can lead to morbidity with prolonged splintage, permanent mallet deformity or requirement for surgical intervention.
- If mallet splints are not readily available in primary care, appropriate prompt splintage can be achieved by guiding patients to standard off-the-shelf mallet splints from online suppliers.

Mucosal malignant melanoma presenting with huge, fleshy, dark-red polyp in the nasal cavity

A 76-year-old woman presented with a 10-day history of left nasal blockage and postnasal drip. She reported frequent nosebleeds, dull headaches and facial numbness on the left side. Nasal endoscopic examination showed a huge, fleshy, dark-red, polypoid mass filling the entire left nasal cavity (*Figures 1* and *2*). Pathological examination showed this to be a mucosal malignant melanoma. The patient underwent wide endoscopic tumour excision.

Mucosal malignant melanomas are uncommon tumours arising from melanocytes and may masquerade both clinically and histopathologically as benign lesions, making accurate early diagnosis and treatment difficult. There is no specific consensus on how to manage mucosal malignant melanomas. The primary treatment is radical surgical resection. The prognosis remains poor, because of high rates of local recurrence or systemic metastasis. Clinicians must rule out the possibility of a sinonasal mucosal malignant melanoma because of its rare, aggressive and invasive nature. BJHM

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Figure 1. Photograph of nasal endoscopic examination showing a huge, dark-red, nasal polyp filling the entire left nasal cavity.

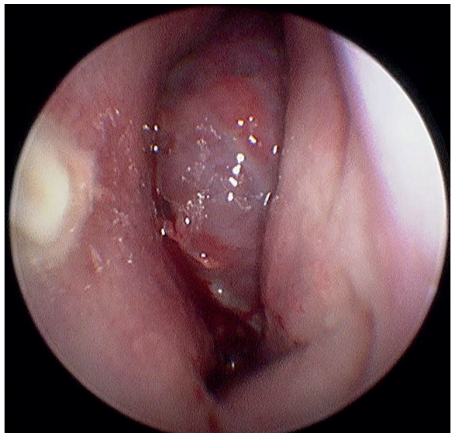

Figure 2. Coronal computed tomography showing soft tissue mass lesion in the left nasal cavity with extension into left maxillary and ethmoid sinuses, and the left orbit.