Using Superficial Curettage to Diagnose Talon Noir

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Talon noir is characterized by darkening of the skin on the feet due to hemorrhage within the stratum corneum. It commonly is observed in athletes who sustain repetitive foot trauma. While talon noir is benign and self-resolving, it is important to differentiate it from acral melanoma due to their similar appearances. Paring of the affected area with a disposable curette is a noninvasive and effective method for diagnosis and treatment of talon noir.

Practice Gap

Brown macules on the feet can pose diagnostic challenges, often raising suspicion of acral melanoma. Talon noir, which is benign and self-resolving, is characterized by dark patches on the skin of the feet due to hemorrhage within the stratum corneum and commonly is observed in athletes who sustain repetitive foot trauma. In one study, nearly 50% (9/20) of talon noir cases initially were misdiagnosed as acral melanoma or melanocytic nevi.[1] Accurate identification of talon noir is essential to prevent unnecessary interventions or delayed treatment of malignant lesions. Here, we describe a low-risk, cost-effective, and time-efficient diagnostic technique for talon noir using a disposable curette to potentially avoid more invasive procedures.

The Technique

A 34-year-old man presented to the dermatology department with a new brown macule on the second toe. The lesion had been present and stable for more than 4 months, showing no changes in shape or color. The patient reported that he was a frequent runner but did not recall any trauma to the toe, and he denied any associated pain, pruritus, or bleeding. Physical examination revealed a 6-mm dark-brown macule on the hyponychium of the left second toe, with numerous petechiae noted on dermoscopic examination. The findings were consistent with talon noir.

Given the clinical suspicion of talon noir, we used a 5-mm disposable curette to gently pare the superficial epidermis. The superficial curettage effectively removed the lesion, leaving behind a healthy epidermis with no pinpoint bleeding, which confirmed the diagnosis of talon noir (Figure). Pathologic changes from acral melanoma reside deeper than talon noir and consequently cannot be effectively removed by superficial curettage alone. Curettage acts as a curative technique for talon noir, but also as a low-risk, cost-effective, and time-efficient diagnostic technique to rule out insidious diagnoses, including acral melanoma.[2] A follow-up examination performed several weeks later showed no pigmentation or recurrence of the lesion in our patient, further supporting the diagnosis of talon noir.

Practice Implications

Talon noir refers to localized accumulation of blood within the epidermis due to repetitive trauma, pressure, and shearing forces on the skin that results in pigmented macules.[3-5] Repetitive trauma damages the microvasculature in areas of the skin with minimal subcutaneous adipose tissue.[6] Talon noir also is known as

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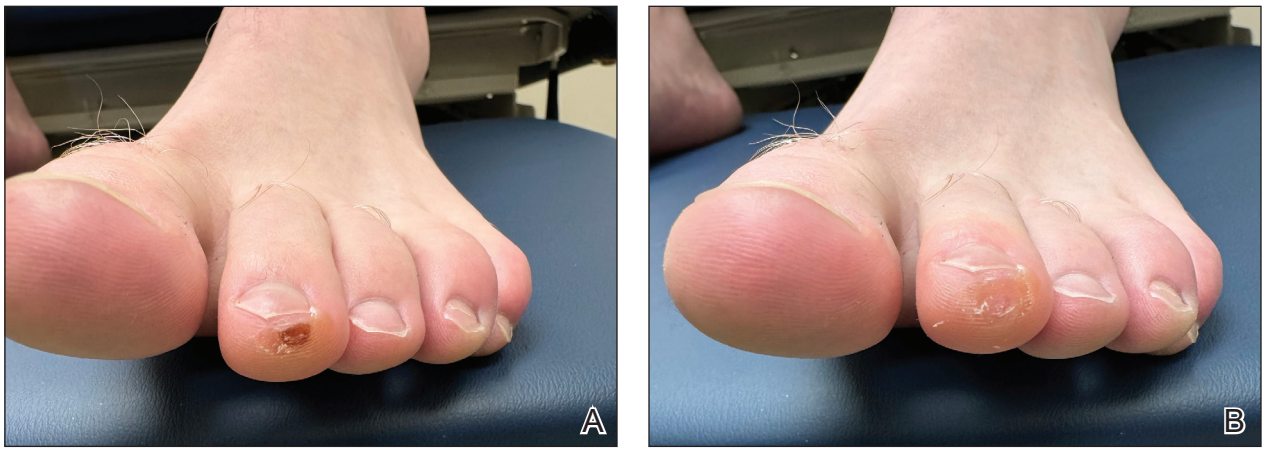

FIGURE. A and B, A brown macule on the hyponychium of the left second toe after partial and full paring of talon noir with a 5-mm disposable curette. After the lesion was fully pared, complete resolution was noted with no pinpoint bleeding, confirming the diagnosis.

subcorneal hematoma, intracorneal hematoma, black heel, hyperkeratosis hemorrhagica, and basketball heel.[1,3] First described by Crissey and Peachey[3] in 1961 as calcaneal petechiae, the condition was identified in basketball players with well-circumscribed, deep-red lesions on the posterior lateral heels, located between the Achilles tendon insertion and calcaneal fat pad.[3] Subsequent reports have documented talon noir in athletes from a range of sports such as tennis and football, whose activities involve rapid directional changes and shearing forces on the feet.[6] Similar lesions, termed *tache noir*, have been observed on the hands of athletes including gymnasts, weightlifters, golfers, and climbers due to repetitive hand trauma.[6] Gross examination reveals blood collecting in the thickened stratum corneum.[5]

The cutaneous manifestations of talon noir can mimic acral melanoma, highlighting the need for dermatologists to understand its clinical, dermoscopic, and microscopic features. Poor patient recall can complicate diagnosis; for instance, in one study only 20% (4/20) of patients remembered the inciting trauma that caused the subcorneal hematomas.[1] Balancing vigilance for melanoma with recognition of more benign conditions such as talon noir—particularly in younger active populations—is essential to minimize patient anxiety and avoid invasive procedures.

Further investigation is warranted in lesions that persist without obvious cause or in those that demonstrate concerning features such as extensive growth. One case of talon noir in a patient with diabetes required an excisional biopsy due to its atypical progression over 1 year with considerable hyperpigmentation and friability.[7] Additional investigation such as dermoscopy may be required with paring of the skin to establish a diagnosis.[1] Using a curette to pare the thickened stratum corneum, which has no nerve endings, does not require anesthetics.[8] In talon noir, paring completely removes the lesion, leaving behind unaffected skin, while melanomas would retain their pigmentation due to melanin in the basal layer.[2]

Talon noir is a benign condition frequently misdiagnosed due to its resemblance to more serious pathologies such as melanoma. Awareness of its clinical and dermoscopic features can promote cost-effective care while reducing unnecessary procedures. Diagnostic paring of the skin with a curette offers a simple and reliable means of distinguishing talon noir from acral melanoma and other potential conditions.

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