Cook's syndrome (CS) is a rare disease, described for the first time by Cooks and all. It is characterized by the association of anonychia and/or congenital onychodystrophy, hypoplasia and/or the absence of distal phalanges of the hands and feet and a bradydactyly of the fifth fingers with digitalization of the thumb [1]. Erysipelas, an infectious dermo-hypodermitis, frequently occurs on lymphedema. We report the case of a patient with congenital anonychia with absence of distal phalanges of the left foot which is a variant of Cook's syndrome revealing by erysipelas on the right leg.

Our patient was treated with amoxicillin protected with a favorable course: complete regression of edematous erythematous placard and persistence of a slight lymphedema (Figure 3).

Prophylactic antibiotic with penicillin delayed every 3 weeks in the long term was prescribed to prevent recurrence, given lymphoedema.

Cook's syndrome is an autosomal dominant ectodermal dysplasia, reported as a rare variety by the Office of Rare Diseases of the National Institutes of Health [2].

Cook et al., [1] described for the first time a syndrome characterized by onychodystrophy or anonychia, brachydactyly of the fifth finger, and digitalization of the thumb, with absence or hypoplasia of distal phalanges of the hands and feet, in seven persons with two generations of the same family, and suspected an autosomal dominant disease [1].

According to Seitz et al., The regulatory proteins signal the for-
formation of bone mesenchyme at the level of the distal phalanx; it develops at the same time as the nails. Nail growth is closely related to the size of the distal end of the phalanx, the growth of the nail is faster on a larger phalanx [3]. Therefore, there is a link between phalanx growth and nail development.

To date, only 20 cases of Cook syndrome have been reported in the literature [4]. Padmavathy L and all. had reported a variant of Cook’s syndrome affecting the 2 small fingers of the hands [5]. A single similar case of anonychia and congenital brachydactyly of the left foot in a 45-year-old male reported in India is probably a variant of this syndrome [2]. We report a second, in a 54-year-old woman revealed by erysipelas of the leg, the latter could be favored by lymphoedema secondary to abnormalities observed during the Cook’s syndrome.

**Conclusion**

Erysipelas on a lymphoedema must make look for the underlying pathologies of which the Cook’s syndrome is part. The trained dermatologist must think about the abnormalities mentioned above and restore a prophylactic treatment.

**References**


