

Jackson Flat Top Traction Device

A table-top traction device designed for fracture fixation in the acetabulum, pelvis, and femur

The light-weight portable device attaches directly to a standard radiolucent flat top table. Features adjustable height and a freely swiveling top. Recommended for use with the disposable sterile kit, which is sold separately.



- A. One end of rope tied to weight source
- B. One end of rope tied to traction attachment



Shown with the Disposable Sterile Kit, which includes one impervious stockinette and one 11 ft. traction rope. (Weight not included.)

PRODUCT NO'S:	
0007	[Jackson Traction Device] This number includes (1) #0008 Disposable Sterile Kit
Sold Separately:	
0008	[Disposable Sterile Kit] Kit Includes: (1) Impervious Stockinette and (1) 11 ft. Traction rope
0008-CASE	[Case of Sterile Kits] Pkg of 10



ISO 13485:2016

FREE TRIAL ON MOST INSTRUMENTS

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By twisting the dial, the device can be raised, lowered or rotated as needed



- Over -

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Jackson Flat Top Traction Device

Generic Set-up and Operation:

It is mounted to the base of the OR table as shown in figure 1.

By twisting the dial, it can be raised, lowered or rotated as needed.

When used for pelvic and acetabular fracture surgery, the device is set up prior to prepping and draping the patient. Traction can be adjusted as needed during the case by the circulating nurse.

When used for hip and femur fracture surgery, it is draped into the field. It is covered by an impervious stockinette followed by a surgical towel to prevent the sterile rope from abrading the drape. The sterile rope is then easily placed into the device by the surgeon and weights are hung off the field where they are easily accessible to the circulating nurse.

Retrograde Femoral Nailing:

The patient is positioned supine on the radiolucent flat-top table according to the preferences of the surgeon.

The Jackson Flat Top Traction Device is mounted at the foot of the table ipsilateral to the injured extremity. It is draped into the surgical field with an impervious stockinette and a surgical towel.

After a standard sterile prep and drape, a distal femoral traction pin is placed. Care should be taken to place it anteriorly in the femur so as not to the nail. Alternatively, if a distal femoral traction pin was placed in the emergency room, it can be prepped into the field. It should be scrutinized radiographically and if not anterior enough should be replaced. A tensioned traction bow that is compatible with a fine wire traction pin works best.

Sterile rope is then tied to the traction bow, run through the Jackson Flat Top Traction Device and off the field where weights are mounted by the circulating nurse. The height of the device and the amount of weight can then be adjusted throughout the case as needed.

The surgeon then proceeds with the procedure as they normally would, benefiting from tireless, consistent and easily adjustable traction.

Pelvic and Acetabular Surgery:

The patient is positioned according the preferences of the surgeon.

The Jackson Flat Top Traction Device is mounted at the foot of the table ipsilateral to the injured extremity. It can either be draped into or out of the field depending on surgeon preference. It can often be draped out during percutaneous procedures. The surgeon may want to drape it in during open acetabular surgery to maintain access to the entire leg.

A traction pin is placed according to surgeon preference as traction utilized as with the other techniques.

Antegrade femoral nailing:

The patient is positioned supine on the radiolucent flat-top table according to the preferences of the surgeon.

The Jackson Flat Top Traction Device is mounted at the foot of the table contralateral to the injured extremity. It is draped into the surgical field with an impervious stockinette and a surgical towel.

After a standard sterile prep and drape, a distal femoral traction pin is placed. Care should be taken to place it anteriorly in the femur so as not to obstruct a long intramedullary nail. Alternatively, if a distal femoral traction pin was placed in the emergency room, it can be prepped into the field. It should be scrutinized radiographically and if not anterior enough should be replaced. If a long intramedullary nail is not planned, the position of the traction pin is less critical and can be determined by surgeon preference. A tensioned traction bow that is compatible with a fine wire traction pin works best.

Sterile rope is then tied to the traction bow, run through the Jackson Flat Top Traction Device and off the field where weights are mounted by the circulating nurse. The height of the device and the amount of weight can then be adjusted throughout the case as needed.

References:

There are several publications in the medical literature where the interested surgeon can learn more about these techniques:

Sanzone AG, Bian W.

Use of a traction bow to facilitate reduction when performing retrograde femoral nailing.

Orthopedics. 2007 Jun;30(6):430-1.

Gardner MJ, Henley MD (eds.)

Harborview Illustrated Tips and Tricks in Fracture Surgery (Textbook)

Wolters Kluwer/Lippincott Williams and Wilkins. 2010.