**Aim:** In South Auckland, patients referred for outpatient chest pain assessment are mainly reviewed in the cardiologist supervised, nurse-led clinic. During the COVID-19 pandemic, a virtual telephone clinic was set up because face-to-face (F2F) clinic visits had ceased. We compared virtual and F2F assessments.

**Method:** We retrospectively analysed demographic, cardiovascular disease (CVD) risk, management and clinical outcome data in the clinic between January 2021 and December 2023.

**Results:** 1397 patients were assessed, 347 had a virtual clinic appointment and 1050 were offered F2F appointments. Patient demographics were similar in both groups, with mean age 58.1 ± 11.9 years , 54.1% male, and median 5-year CVD risk was 5-10%. Exercise tolerance tests (ETT) were performed less in virtual clinics compared to F2F patients (19.6 vs 78.7%, p <0.001). CT coronary angiography was performed equally in both clinics (35.7% virtual vs 33.1% F2F, p=0.376), as was invasive coronary angiography (9.8% vs 12.1%, p=0.245).

Of those who had coronary assessment, obstructive disease was demonstrated in 30.5% (25.7% virtual vs 32.1% F2F, p=0.197), with 69.4% and 57.8% of these requiring revascularisation (p=0.204). Over a median follow-up of 1.78 years, combined rates of myocardial infarction and cardiac death were similar (1.2% vs 0.76%, p=0.506).

**Conclusion:** Virtual nurse-led clinics allowed assessment of patients with stable chest pain without adverse outcome. Use of less ETT during the virtual clinics did not have a negative impact on the rate of anatomical coronary imaging or CAD revascularisation and may have implications on resource use.